COMMONWEALTH OF KENTUCKY

Personnel Cabinet
Department of Employee Insurance

Updated March 2010

Administration Manual

Kentucky
UNBRIDLED SPIRIT

This manual has been designed to assist in the proper administration of the Kentucky Employees' Health Plan (KEHP). It is intended for use by Insurance Coordinators, agency personnel and KEHP members. All sample letters are available on the Department of Employee Insurance's (DEI) Web site. Insurance Coordinators may download the letters from the Web site and customize them for the individual agency's use. If the Insurance Coordinator does not have access to the Web site, please contact DEI's Member Services Branch.

Contact Information

Personnel Cabinet
Department of Employee Insurance (DEI)
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Frankfort, KY 40601
http://kehp.ky.gov

DIVISION OF INSURANCE ADMINISTRATION

Enrollment Information Branch
(502) 564-1205
(502) 564-1085 (Fax)

Member Services Branch
(888) 581-8834
(502) 564-6534
(502) 564-5278 (Fax)

DIVISION OF FINANCIAL AND DATA SERVICES

Data Analysis Branch
(502) 564-7101
(502) 564-0715 (Fax)

Financial Management Branch
(502) 564-9097
(502) 564-0715 (Fax)

Flexible Benefits Branch
(502) 564-0350
(502) 564-0351
(502) 564-0364 (Fax)

COMMISSIONER'S OFFICE
(502) 564-0358
(502) 564-5278 (Fax)

Employee Health Insurance Wellness
(502) 564-0358
http://personnel.ky.gov/benefits/wellness/default.htm

The Department of Employee Insurance does not administer life insurance benefits, however, because the Kentucky Human Resource Information System (KHRIS) combines the life and health information, listed below is the contact information for the Life Insurance Branch:

Personnel Cabinet
Office of Employee Relations
Life Insurance Branch
(502) 564-4774
(800) 267-8352

INTRODUCTION

I Self-Funded

The Kentucky Employees' Health Plan (KEHP) is a self-funded plan, which means the Commonwealth assumes the risk of our claims and pays an administrative fee to Humana, the KEHP's Third Party Administrator (TPA), and to Express Scripts, Inc., the Pharmacy Benefits Manager (PBM), to process claims and to access provider networks.

II KEHP Partners

Humana and Express Scripts, Inc. have established relationships with several business partners to assist with the administration of the KEHP and to provide specialized services to our employees. These partners have been approved by the Commonwealth of Kentucky and comply with all privacy regulations.

Humana

- **Active*Health* Management** offers Informed Care Management (Disease Management), Case Management and Utilization Management programs to the KEHP members.

- **Ceridian COBRA Continuation Services** administers COBRA continuation services for KEHP members. Ceridian uses an on-line enrollment system called WebQE as the method for COBRA notification. All Insurance Coordinators must enter an employee's new hire, termination and COBRA Qualifying Event information via WebQE. Ceridian is responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.

- **LifeSynch (formerly CorpHealth, Inc**.) partners with Humana to provide mental health and substance abuse services, as well as certain wellness benefits such as health coaching.

- **Virgin HealthMiles** partners with Humana to make a walking/activity program available to members of the KEHP.

Express Scripts

- **CuraScript Pharmacy** provides mail order services for certain oral and injectable specialty medications. There are certain specialty drugs which are required to be filled through CuraScript. Members are allowed to fill the first prescription at the retail pharmacy. Express Scripts then advises the member that any future prescriptions are to be filled through CuraScript. CuraScript mails medications to the member's home, in addition to all needed supplies, at no additional cost.

TABLE OF CONTENTS

ELIGIBILITY AND ENROLLMENT

I Eligible Participants

NOTE: For purposes of this Administration Manual, the term "employee" includes regularly employed employees, retirees and/or beneficiaries, classified or certified school employees and COBRA participants.

NOTE: Employees, retirees or COBRA participants and/or their dependents may only be covered under **one** state-sponsored plan.

A. Regularly employed employees

Employees of the following agencies who contribute to one of the state-sponsored retirement systems, or who are otherwise defined in KRS 18A.225, are eligible to participate:

State Agencies;
Boards of Education;
Health Departments; and
Quasi Agencies

B. Elected School Board Officials

Participate on a post-tax basis; employee is responsible for total premiums.

C. Retirees

Retirees, under age 65 or age 65 or older and not eligible for Medicare, who draw a monthly retirement check from any of the following retirement systems, are eligible to participate according to plan guidelines:

- Judicial Retirement Plan;
- Legislators Retirement Plan;
- Kentucky Community and Technical College Retirement System (KCTCRS);
- Kentucky Retirement Systems (KRS), which include:
  - County Employees Retirement System (CERS);
  - Kentucky Employees Retirement System (KERS);

- State Police Retirement System (SPRS).
- Kentucky Teachers' Retirement System (KTRS)

Note: Retirees who are Medicare eligible and **actively** employed with a participating agency must contact their retirement system to determine if they must drop their Medicare Supplement Plan. These employees are eligible to participate in KEHP.

- KRS retirees should ask for a Health Care Counselor

D. COBRA qualified beneficiaries

Employees and/or eligible dependents that elect COBRA continuous coverage through KEHP

E. Dependents

The following dependents are eligible for participation under the Kentucky Employees Health Plan (KEHP):

- An employee's spouse under an existing legal marriage
- An employee's unmarried dependent child

KEHP dependent child eligibility rules

Pursuant to KRS 304.17A.256, KEHP rules for Unmarried Dependent Children. (For purposes of Health Plan eligibility):

1. **Unmarried.** Individual is not married or not in an existing legal marriage. This would include a divorced individual. This would not include separation from marriage, domestic partner, etc; **and**

2. **Dependent.** Planholder is primarily responsible for individual's maintenance and support; which includes lodging, **and**

3. **Child.** i.e. Child means an individual who is -
   (i) a son, daughter, stepson, or stepdaughter of the employee, **or**
   (ii) an eligible foster child of the employee (an eligible foster child means an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), **or**
   (iii) an adopted child (a legally adopted individual of the employee, or an individual who is lawfully placed with the employee for legal adoption by the employee, shall be treated as a child of such individual by blood). **and**
4. **Age.** Unmarried *dependent* child is under age 25.

NOTE: A *dependent* must meet KEHP's eligibility rules before an *employee*/planholder may add the *dependent* to the *Plan*. Upon reaching age 25, the *dependent* child will become ineligible and be terminated as a *dependent* at the end of the month in which the birthday occurs.

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a *dependent* to the *Plan* who does not meet the KEHP eligibility rules.

NOTE: The Department of Employee Insurance reserves the right to request supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan.

Temporary absences from living in the members home, such as while attending school, are permitted. For other instances qualifying as "temporary absence" see *MICHELLE'S LAW under Apendix L, Additional Notices*

A dependent child who does not live with the employee, but for whom the employee has a legal obligation under a divorce decree, court order or administrative order to provide for the Healthcare expenses of the child, remains eligible for coverage under the Plan.

A stepchild for whom the member's spouse has a legal obligation under a divorce decree, court order or administrative order to provide for the Healthcare expenses of the child, remains eligible for coverage under the Plan **ONLY** if the dependent meets all other dependent eligibility requirements.

A grandchild meets the above eligibility rules only when the employee has guardianship or custody papers.

Age restrictions do not apply to a child that is permanently and totally disabled.

For purposes of our health insurance Plan, an unmarried disabled dependent may *continue* to be covered under the Plan beyond the age limit specified under the eligibility rules if the disability started before the limiting age and is medically certified by a physician.

A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of a continuous or indefinite duration. The KEHP's Third Party Administrator may require proof of the dependent's disability at least annually.

A disabled dependent not covered under the Plan prior to the limiting age may only be enrolled in the KEHP if he/she **loses** other health insurance coverage.

If, during Open Enrollment, you wish to enroll a disabled dependent that is past the limiting age specified under the eligibility rules, you must show proof that the disabled dependent has

experienced a loss of coverage. Other than Open Enrollment, the request to add the disabled dependent must be made within 35 calendar days of the Qualifying Event.

NOTE: For active employees dependent coverage is paid on a pre-tax basis up to the end of the year in which said child turns 23. DEI automatically drops the dependent child as of December 31 of the year in which the dependent child turns 23. If the employee wishes to continue to cover that dependent child, he/she must enroll them during Open Enrollment, if eligible. If the dependent child does not qualify for pre-tax status as a "qualified child" or "qualified relative", he/she must be enrolled as a post-tax dependent. **The employee must re-enroll the dependent each year until they turn 25, providing they continue to qualify as a dependent.**

Working Families Tax Relief Act (WFTRA) of 2004

After confirming KEHP *dependent* eligibility above, the next step is to indicate whether the *dependent* qualifies as a "Federal Tax Dependent" for purposes of the KEHP's Section 125 Cafeteria Plan.

If *your* dependent qualifies then he/she will be covered on a pre-tax basis . If not, he/she is still eligible but coverage must be on a post-tax basis.

In the Working Families Tax Relief Act (WFTRA) of 2004 (I.R.C. § 152), Congress changed the way the Internal Revenue Service treats children under the tax code. This change may affect planholders if they pay their health insurance *premiums* pre-tax through the KEHP's Section 125 Cafeteria Plan. The WFTRA of 2004 developed a new definition for "qualified child" and "qualified relative." An *employee* will NOT be able to pay *dependent premiums* on a pre-tax basis if the *employee's*/planholder's *dependent(s)* **CANNOT MEET ONE** of these definitions (qualifying child or qualifying relative).

The KEHP dependent eligibility rules shall always be met before a dependent can be enrolled in the KEHP.

Pursuant to I.R.C. § 152, the definitions are as follows:

A "**qualifying child**" (QC) of an *employee* under Code § 152, there are **four tests—the relationship, residency, age, and limited self-support tests.**

A "**qualifying child**" (QC) is a child who unmarried and:

- Has a specific, family-type relationship to the *member* taxpayer (See definition of "Child" above). (The **relationship test**);
- Resides with the *member* in his/her household for more than half of the tax year (with certain exceptions such as "temporary absences" if a full-time student). (The **residency test**);
- Is under age 19 and not a full-time student (or under age 24 if a fulltime student) as of the end of the *calendar year* in which the *member's* taxable year begins. A "student" means an individual who, during each of five calendar months during the *calendar year* in which the *employee's* taxable year begins, is a full-time student at an educational organization (**The age test);**
    - There is no age requirement if a child is permanently and totally disabled;

- Individual must not provide more than half of his or her own support for the *calendar year* in which the taxable year of the *employee* begins (The limited self-support test).

A **"qualifying relative"** (QR) of an *employee* under Code § 152(d), has are **three tests—the relationship, support,** and **not anyone's qualifying child tests.**

A **"qualifying relative" (QR)** is a child or other individual who:

- Has a specific, family-type relationship to the *member* taxpayer (See definition of "Child" above) (**The relationship test**);
- A person cannot be a "qualifying relative" of the *member* if at any time during the taxable year the relationship between the *member* and the person violates federal, state, or local law; (**The relationship test**);
- Receives over half of his/her own support from the *member*-taxpayer. Support includes food, shelter, clothing, medical and dental care, education, and the like.) (**The support test**);
- Is not anyone's (including the *member's*) "qualifying child." (See definition above) (The not anyone's qualifying child test).

NOTE: An individual generally will not be a *dependent* under Code § 152 if he or she is a *dependent* of a Code § 152 *dependent*, a married *dependent* filing a joint tax return, or a citizen or national of a country other than the United States.

NOTE: Under Code § 152(e), a special rule determines which one of a child's parents is entitled to claim the child as a qualifying child or as a qualifying relative when the parents are divorced, separated, or living apart. Generally, the parent most likely to claim the child is the "custodial parent". Because one of the requirements to be a qualifying child is that the child must have the same principal place of abode as the *employee* for more than half of the *employee's* taxable year ordinarily the noncustodial parent generally would not be entitled to claim the child as a qualifying child or qualifying relative. But under Code § 152(e) if specific conditions are met, a child can be the qualifying child or qualifying relative of the noncustodial parent instead. Please consult *your* tax advisor to determine if *you* meet the requirements of this special rule.

IMPORTANT: I.R.C. § 152 does not change KEHP's eligibility rules. It does not create any new category of eligible dependents, or make people who were previously ineligible for coverage now eligible. A dependent shall meet KEHP's eligibility rules before an employee may add the dependent to the Plan. **Adding a dependent to the Plan who does not meet the KEHP eligibility rules may be considered insurance fraud.**

TAX CONSEQUENCES

Paying dependent premiums on a pre-tax basis for an individual who does not meet the definition of "qualifying child" or "qualifying relative" may be in violation of federal tax law. However, if a dependent child does not meet the requirements of a I.R.C. § 152 qualifying child or qualifying relative he or she may be eligible to be covered as a dependent on a post-tax basis pursuant to KEHP plan eligibility defined by KRS 304.17A.256.

Age limits	Qualified Child Eligibility	Qualified Relative Eligibility	Tax treatment
0- to 19th birthday	Must meet KEHP dependent definition and Q.C. definition (does not require full-time student status)	Must meet KEHP dependent definition and Q.R. definition	Pre-tax
19- to end of 23rd year	Must meet KEHP dependent definition and Q.C. definition (**requires full-time student status**)	Must meet KEHP dependent definition and Q.R. definition	Pre-tax
Up to 25th birthday	Cannot meet Q.C. definition due to age.	Must meet KEHP dependent definition and Q.R. definition	Post-tax, but may be eligible for Pre-tax

NOTE: If at any time during the year, the post-tax child is dropped from the plan due to ineligibility or a Qualifying Event, the plan will default back to pre-tax status as of the effective date of the new plan on which the post-tax child is no longer covered.

Eligibility Limitations

Employees, retirees and COBRA participants may only be covered under one state sponsored plan.

Dependents may only be covered under one state sponsored plan. In the case of a child from divorced parents, the parent with custody shall have first option to cover the dependent child, unless both employees agree otherwise in writing.

II Employer Contribution

A. Agencies Covered Under KRS 18A and Technical Schools

- Employees are eligible for the employer contribution for the current semi-monthly period after the initial waiting period for new hire, if during the **previous** semi-monthly period, they use:
  - any combination of workdays;
  - paid leave; and/or
  - Family Medical Leave (Refer to Chapter 6 for additional information on FMLA).

- Employees who are unable to work and elect to use paid leave to qualify for the employer contribution must use those days consecutively.

- Employees returning from leave without pay (LWOP) must work at least one day in the previous semi-monthly period to qualify for the employer contribution for the

current semi-monthly period (refer to Chapter 6 for additional information on LWOP).

- Employees must work at least one day (or have paid leave) during the previous semi-monthly period in order to be eligible for the employer contribution for the next period. Coverage for employees who do not meet this requirement should be terminated and the employee must be offered COBRA continuation coverage

NOTE: Semi-monthly period is defined as follows – first day of the month through the fifteenth day of the month and the sixteenth through the last day of the month, regardless of whether the employer is paid monthly or semi-monthly.

B. Agencies NOT Covered Under KRS 18A

- Employees are eligible for the employer contribution for the current semi-monthly period after the initial waiting period for new hire, if during **that** semi-monthly period, they use:
  - any combination of workdays;
  - paid leave; and/or
  - Family Medical Leave (Refer to Chapter 6 for additional information on FMLA).

- Employees who are unable to work and elect to use paid leave to qualify for the employer contribution must use those days consecutively.

- Employees returning from leave without pay (LWOP) must work at least one day in the semi-monthly period to qualify for the employer contribution for that semi-monthly period (refer to Chapter 6 for additional information on LWOP).

- Employees must work at least one day (or have paid leave) during the semi-monthly period in order to be eligible for the employer contribution for that semi-monthly period. Coverage for employees who do not meet this requirement should be terminated and the employee must be offered COBRA continuation coverage

NOTE: Semi-monthly period is defined as follows – first day of the month through the fifteenth day of the month and the sixteenth through the last day of the month, regardless of whether the employer is paid monthly or semi-monthly.

C. Quasi' governmental agencies

Insurance Coordinators for quasi-governmental agencies should refer to their administrative regulations or internal policies for the definition of a regularly employed employee entitled to employer contributions.

D. Dual employment

An employee who is considered regularly employed for two participating employers (and meets the eligibility requirements for each employer) is eligible for the employer

contribution from each employer. However, an employee is only eligible to participate in one KEHP health insurance plan. Therefore, a dual employee may take a KEHP health insurance plan through one employer and waive KEHP coverage through the other employer and enroll in a stand-alone Health Reimbursement Account (HRA)if eligible or waive coverage through both employers and enroll in a stand-alone HRA with both.

III Levels of Coverage

- **Single** – covers the employee only.
- **Parent Plus** – covers the employee and one or more eligible children.
- **Couple** – covers the employee and the employee's spouse only.
- **Family** – covers the employee, spouse and one or more eligible children.

IV Cross-Reference Payment Option

Cross-reference is a payment option available to two legally married participating employees or retirees in KEHP. Upon loss of eligibility (due to, but not limited to, loss of employment, starting LWOP or changing from full to part-time employment), the former employee has lost planholder eligibility status and can only be covered as a dependent on that existing plan.

If either employee loses employment/eligibility for any reason:

- the Family Cross-Reference payment option terminates as eligibility to participate in the Family Cross-Reference payment option has ceased.
- the remaining planholder will be permitted to move from "family" coverage to either "parent plus" or "single" coverage. When the Cross Reference option terminates the remaining planholder will default to "parent plus". To change to a "single" level a Drop Form, indicating the desired level of coverage, must be received within 35 calendar days after the date of the qualifying event.
- If the drop form does not indicate the level of coverage or is not received within the 35 calendar days the default level will remain until the next Open Enrollment, unless an appropriate Qualifying Event occurs.
- the employee may **NOT** change their plan option.

If the remaining planholder wishes to elect dependent coverage for that former employee:

- he/she MUST request the change to their dependent coverage (change from Parent Plus to Family plan) within 35 days of that loss of planholder status.

As the Insurance Coordinator, you should explain this to any employee selecting the family cross-reference payment option.

NOTE: If a post-tax child is added/covered by the cross-reference payment option, both active employees plan holders will default to post-tax status. If one or both are retirees, post-tax is not an issue for that retiree.

A. Cross-reference requirements

To be eligible to select the cross-reference payment option with a family plan, each of the following requirements must be met:

- The employees must be legally married with at least one dependent ;
- The employees must be eligible employees or retirees* of a group participating in KEHP;
- The employees must elect the same coverage; and
- The Enrollment Application must be completed, signed, and dated by the deadline by **both** employees and filed with their employers' Insurance Coordinators. Both Insurance Coordinator signatures must be on the form.

Failure to meet any one of the above requirements will make the employees ineligible for the cross-reference payment option.

**Per the Judicial and Legislators Retirement System, retirees of the Judicial and Legislators Retirement Plans are not eligible to elect the cross-reference payment option.*

B. Family plan

Two legally married, eligible employees of KEHP may enroll themselves and their eligible dependent children in a family plan and elect the cross-reference payment option. The cross-reference employee contribution will be deducted from each employee's paycheck.

C. When can the cross-reference payment option be selected?

Employees may select the cross-reference payment option at the following times:

- **During the Open Enrollment** period;
- **At the time of hire** with a participating group - the newly hired employee must elect coverage to match the existing employee/retiree's elections and the existing employee becomes the primary planholder. If the existing employee has waived health insurance, the employee, newly hired spouse, or dependent must have experienced a loss of coverage and sign and date the Enrollment Application requesting to begin a cross-reference payment option within 35 calendar days of the loss. Depending on how the dates fall, the existing employee may have to pay full family premium for the first month.

  Example: Jane Doe works for a board of education. She waives and receives the stand-alone HRA. Her spouse, John, is hired by the local health department. He elects to start a cross-reference with Jane, effective June 1. The first action Jane must take is to establish herself as a planholder with an insurance plan. She must submit a Loss of Coverage Qualifying Event. If her Qualifying Event is effective

before June 1, she must start her insurance as a non-cross-referenced member. Then, June 1, she may switch to the cross-reference with her spouse John.

- **At retirement** – newly retired retirees of a participating retirement system can elect a cross-reference payment option, if applicable. **The new retiree must elect coverage to match the existing employee/retiree's elections and the existing employee becomes the primary plan holder.** If the existing plan holder is a retiree (not an active employee), the existing retiree is primary planholder until Open Enrollment, at which time they may switch Primary/Secondary status. The active employee will always be the primary planholder for cross-reference; the retiree will be the secondary planholder. **Retirees are not eligible for the Commonwealth Maximum Choice Plan**; or

- **During certain Qualifying Events** - When two employees experience a Qualifying Event, which will allow their plans to merge into one cross-reference payment option, **one employee may change their plan option (Commonwealth Standard PPO, Commonwealth Optimum PPO, Commonwealth Capitol Choice or Commonwealth Maximum Choice) in order to start a cross-reference payment option.** This is not a Qualifying Event to allow both planholders to elect a new level of coverage (i.e. if they have two different plan options, they must select which plan they desire and that planholder will be the primary planholder for the cross-reference payment option) or

- If an employee's spouse's **employer joins the KEHP** as a new group during the Plan Year, the employee and their spouse WILL be allowed to elect a cross-reference payment option because the spouse has become a new planholder. They must submit paper applications.

D. Ending the cross-reference payment option

Employees will not be eligible to continue the cross-reference payment option if any of the following events occur:

- Termination of employment or loss of employer paid benefit eligibility.

- New retirement – newly retired retirees of a participating retirement system can elect to stop their cross-reference payment option. The spouse of the new retiree will be enrolled in a coverage level that corresponds to the new retiree's level*. No plan option changes will be allowed for the active employee.

- Either participant loses eligibility for coverage due to a LWOP.

- Experiencing a Qualifying Event that allows employees to drop their spouse
  - Changes in plan options (Commonwealth Standard PPO, Commonwealth Optimum PPO, Commonwealth Capitol Choice or Commonwealth Maximum Choice) will NOT be allowed.

- Experiencing a Qualifying Event that allows employees to drop their only dependent child – in this situation, the covered employees will be assigned to two single plans.
  - Changes in plan options (Commonwealth Standard PPO, Commonwealth Optimum PPO, Commonwealth Capitol Choice or Commonwealth Maximum Choice) will NOT be allowed.

An employee in a cross-reference payment option who terminates employment IS eligible for COBRA coverage. You must enter these employees in Ceridian's WebQE.

***Retirees are not eligible for the Commonwealth Maximum Choice Plan.**

V Initial Enrollment

Coverage for new employees will begin on the first day of the second calendar month following the employees' hire date. For example, if employment begins anytime in August, the employee is eligible for coverage October 1.

New employees must complete, sign and date a new application, or enroll on-line to apply for coverage or waive their coverage within the first 30 calendar days of employment.

31 -35 Day Enrollment: Enrollment applications signed between 31 and 35 days after the employee hire date may be accepted through the Grievance Process described in the KEHP Handbook. The granting of the extra 5 days is only available as a matter of last resort and can only be granted through the grievance process.

Employees who fail to make their health insurance elections or waive their coverage within the designated time frame will not have coverage and will not be allowed to enroll until the next Open Enrollment period, unless an appropriate Qualifying Event occurs. **Employees who fail to enroll will automatically default to a forced waiver. Forced waivers will not receive the HRA funds.**

NOTE TO INSURANCE COORDINATORS OF QUASI-GOVERNMENTAL AGENCIES:

Refer to your administrative regulations or internal policies. If your probationary period for benefits eligibility is longer than described above your employees must sign the Enrollment Application no earlier than 60 days prior to the effective date and **no later than 30 days prior** to the effective date of coverage. Employees who fail to make their health insurance elections or waive their coverage within the deadline will not have coverage and will not be allowed to enroll until the next Open Enrollment period, unless an appropriate Qualifying Event occurs. For instance, if your agency has a 6-month waiting period before health insurance coverage is effective and the employee is hired on January 1, the employee must

sign the application no earlier than May 1 and no later than June 1 (between May 1 and May 30) in order to be effective July 1.

VI Waiving Coverage

A. Waivers with an HRA (stand alone HRA) will only be accepted:

- During the annual Open Enrollment period;
- From new employees;
- From employees with an 11 or more calendar day break in service (in employment);
- From employees who experience a different open enrollment that occurs between the KEHP's open enrollment and December 31 (i.e. between mid October and December 31); or
- From employees returning from Military Leave who are remaining on TRICARE.

To waive coverage, employees must complete all applicable sections of the Enrollment Application or enroll online, if available/applicable.

B. Redirection of the employer contribution

Redirection is the ability of an employee to stop employer funds from going into a stand-alone HRA in order to start receiving an employer contribution toward a health insurance plan as a result of experiencing a permitted Qualifying Event (Refer to Chapter 3 for information on which Qualifying Events allow redirection).

- Employees who are enrolled in a health insurance plan **will not** be allowed to terminate coverage and enroll in a stand alone HRA in the middle of a plan year, unless:
  - They have a break in service of more than 11 scheduled working days;
  - They experience a different Open Enrollment period that occurs between the KEHP's open enrollment and December 31 (i.e. between mid October and December 31). This only applies to changes to be effective the beginning of the KEHP Plan Year – no mid-year election changes are allowed for this situation. or
  - They are returning from military leave and remaining on TRICARE.
  - They experience a permitted Qualifying Event (refer to Chapter 3)

C. Waiver with no HRA Forced Waiver

Employees who do not complete, sign and date an Enrollment Application (or enroll on-line) within 30 calendar days, or if a grievance is filed 35 calendar days from their date of hire (30 calendar days before their effective date for some quasi-governmental groups) or during the Open Enrollment period will not have health insurance. They will be defaulted to a "forced waiver" and not be eligible to enroll until the next Open Enrollment period or until they experience a Qualifying Event that would allow them to enroll.

VII Open Enrollment

Open Enrollment is a period of time for employees to make plan elections for the upcoming Plan Year. Open Enrollment requirements may vary during each Open Enrollment period. Therefore, DEI will provide specific Open Enrollment guidelines to all employees during each period.

After Open Enrollment elections have been made, employees may only change their elections under very specific circumstances. Such changes are regulated by federal law and are referred to as "permitted election changes" under the federal regulations. DEI refers to these events as Qualifying Events. The requested change must always be consistent with the Qualifying Event.

NOTE: Children covered due to a National Medical Support Notice directed at the employer may not be dropped during open Enrollment. The member must submit Qualifying Event paperwork with a new National Medical Support Notice authorizing dropping the dependent.

VIII Coverage Changes

If an employee experiences a permitted election change as defined in the federal regulations, an employee must submit the appropriate Qualifying Event form and supporting documentation according to the guidelines in Chapter 3. The appropriate paperwork must be signed and dated by the employee (or both employees if cross-reference) within the specified timelines in Chapter 3. If the timeline is exceeded, the request for change will be denied.

IX Transition from Dependent to New Employee

Dependent children who are already covered as dependents in the KEHP and become employed by a participating employer have the following options upon hire: a) Become a planholder or b) remain covered as a dependent under their parent's plan.

A. Dependents Become Planholders

The newly hired dependent child(ren):

- Must complete, sign, and date an Enrollment Application as a new employee within the deadline; and
- If the dependent elects health insurance coverage (not waiver or waiver HRA) their eligibility as a dependent on the parent's plan ends on the day prior to the effective date of their coverage as a planholder and the dependent should be dropped from the parent's plan.
- If the dependent elects a waiver or stand-alone HRA the dependent will NOT be dropped from their parent's plan but the parent must follow the steps in Section B below.

NOTE: If the dependent has elected health coverage, waived coverage or selected a stand-alone HRA, DEI will copy/pend both the parent's and the dependent's new election and notify the Insurance Coordinator (through the GHI email on the web enrollment system) of both the parent and dependent to submit a Dependent Drop Form signed by the parent or the documents to certify eligibility as specified in Section B below. **DEI WILL NOT automatically remove the dependent child from the parent's plan and change their level of coverage.**

Because the copy/pend changes on both plans are pended the Insurance Coordinator for both parent and dependent will receive notification through the IC email box that the Parent **MUST** complete the Dependent Drop Form or certify dependent eligibility. The Insurance Coordinator **MUST** notify the parent(s).

B. Remain as a dependents on their parent's plan

If, upon hire, covered dependents still meet the dependent eligibility requirements, the affected parties must do the following:

- The newly hired dependent child must complete an Enrollment Application to waive coverage or elect a stand-alone HRA no later than 30 calendar days from date of hire. (Applications signed between 31-35 days must apply through the grievance process); and
- The newly hired dependent child must also submit a notarized letter from the parent(s), as explained below:
  - The parent, under whom the new employee is still covered as a dependent child, must provide DEI with a written request to keep the child enrolled in their plan. The request must be notarized and it must state that the child still meets all dependent eligibility requirements of the Plan **after employment**. If the application for a stand-alone waiver is signed and dated within 30 calendar days of employment, the new employee will be enrolled in the HRA (if eligible/participating).

X New Employees, Transfers and Rehires

New Employees are employees newly hired by your agency. They may or may not have worked for another KEHP participating agency as of the business day prior to their hire date with your agency.

In order to determine the effective date of coverage with your agency and whether or not your newly hired employees are allowed to make changes to their health insurance elections, review the scenarios below:

- **Newly hired employees: (Did not work for a KEHP participating agency prior to their employment with your agency.)**

Under this scenario, the following apply:

- The effective date of their health insurance elections is the first day of the second calendar month following their hire date. For example, if employment begins anytime in August, the employees are eligible for coverage October 1. (See Chapter 1, Section V, Initial Enrollment, for details)
- The newly hired employees are allowed to enroll in any available plan or waive health insurance coverage and enroll in stand-alone HRA, if eligible (all enrollment procedures, deadlines and restrictions apply).

- **Newly hired employees are transferring directly from another KEHP participating agency without a break in service (in employment).**

  Under this scenario, the following apply:

  - The new employees are considered **"clean"** transfers.
  - The effective date of their health insurance elections is the first day of the semi-monthly period following their termination date of coverage with the previous agency. This may require your agency to begin providing the employer contribution for the month in which the employee was hired.
    Example: Employment begins on August 1 and their last day of work with the previous employer was July 31st. Your agency must provide coverage and the employer contribution for the month of August.
  - **The newly hired employees are NOT allowed to make new health insurance elections.** The Insurance Coordinator must submit an Update Form transferring their prior elections.
  - There may be some employees who terminate employment at one agency at the end of a week (before a weekend) and begin employment with the new agency at the beginning of the next work week (usually Monday), or during a holiday. Employees in that situation will be considered to have **had no break in service (in employment)** because weekends and/or holidays are not regularly scheduled working days.

NOTE: Some employees' weekends are not Saturday/Sunday. Their weekend may fall in the middle of the week. In that case, those regularly scheduled days off would not count as a break in service. Please notify DEI if this occurs and we will make the appropriate adjustments.

- **Newly hired employees are transferring from another KEHP participating agency and have experienced a break in service (in employment).**

  Under this scenario, the following apply:

  - **If the break in service is 1 to 10 working days:** 

    - These newly hired employees are considered "small break" transfers.
    - They may experience a half month break in health insurance coverage.

- If the 1-10 day break occurs within the same semi-monthly pay period there is no break in coverage.
- If the 1-10 day break occurs within different semi-monthly pay periods there is a ½ month break in coverage.

***Example 1*: *No break in coverage*.** Employee stops working at old company 7/19, health insurance stops on 7/31. The employee is hired by a new company on 7/24, with health insurance beginning on 8/1. This employee does not experience a break in coverage.

***Example 2*: Half month break in coverage.** Employee stops working at old company 8/10, (1st-15 period) health insurance stops on 8/15. The employee is hired by a new company on 8/18(16th-end of month), with health insurance beginning on 9/1. This employee will have a ½ month break in coverage.

- **They are NOT allowed to make new health insurance elections**. Employees will be allowed to make new coverage elections only if they experienced a Qualifying Event (all Qualifying Event guidelines apply) or if an Open Enrollment period occurred during the break in service. If this is the case, the employees must submit an Enrollment Application requesting the permitted change(s).

- **If the break in service is 11 or more working days, the following apply:**
  - These newly hired employees are **considered new employees**.
  - The effective date of their health insurance elections is the first day of the second calendar month following their hire date. For example, if employment begins anytime in August, the employees are eligible for coverage October 1. (See Chapter 1, Section V, Initial Enrollment, for details)
  - **The newly hired employees are allowed to enroll in any available plan, waive health insurance coverage and enroll in an HRA if eligible, make changes to smoking status if needed, (all enrollment procedures, deadlines and restrictions apply.** See Chapter 1, Section V, Initial Enrollment, for details).

    Example: Employee stops working at old company 2/10, health insurance stops on 2/15. The employee is hired by a new company on 2/22, with health insurance beginning on 4/1. The employee will have a month and ½ break in coverage. However, with the new company, the employee is allowed to make new coverage elections as well as change his/her smoking status.

XI Boards of Education

Update forms or Special BOE forms for Pink Slipped Employees must be completed within 10 days of the occurrence.

A. Coverage Terminations

- **Contract Fulfilled and Summer Premiums Deducted / Available:**

School district employees who work under a July 1st through June 30th contract will be allowed to retain coverage through August 31st provided they:

a) fulfilled the terms of their contract and
b) the employee premiums for their summer coverage are deducted from their last paycheck(s).

At the end of the contract, if they are non-renewed or the district has issued a **"pink-slip"** to them with the intention of re-hiring them in the fall, the same coverage extension rules apply. This information should be sent to DEI on a special Board of Education Update Form for Pink Slipped Employees. The employment end date will be the 6/30 contract end date and the insurance termination date will be the last day of the month their coverage is paid for, i.e. 7/31 or 8/31.

Note: Employees whose health insurance premiums or Waiver HRA premiums are fully paid by the state and who qualify for the extended summer coverage will be allowed to retain their coverage.

- **Contract Fulfilled but Summer Premiums NOT Deducted / Available:**
  If July and August premiums are not deducted from the last paycheck(s), but the employees have fulfilled the terms of their contract, coverage will end on the last day of the semi-monthly period for which premiums were paid in full. On the Update Form, the employment end date will be the 6/30 contract end date and the insurance termination date will be the last day of the semi-monthly period for which premiums were paid in full.

- **Contract Fulfilled and Employee Retires:**
  For those employees who retire at the end of their contract, coverage will stop on June 30th and all premiums for June are due from the district. Retirement will pick up coverage according to their rules which generally means a July 1st coverage effective date. However, final determination of when retirement coverage begins is subject to the rules of that retirement system. The Retirement System, like all other agencies, is responsible for processing this matter in a timely manner to ensure proper coverage. **On the Update Form, please indicate a 6/30 end date for both employment and coverage and write "Retirement" on the form.**

- **Contract NOT Fulfilled:**
  Employees who stop working before the last contract day; or, who fail to fulfill the terms of their employment contract; should be terminated from coverage following the regular employment termination rules indicated below. This information should be communicated to DEI on an Update Form.

  Employment stops between 1st and 15th:
  - Health Insurance ends on 15th of same month
  - FSA/HRA end on last day of work

  Employment stops between 16th and 31st:
  - Health Insurance ends on last day of same month
  - FSA/HRA end on last day of work

B. Summer Transfers

- **What is a Summer Transfer?**
  School district employees who work the last day of their contract under the old school district and the first day of their contract under the new school district are classified as "Summer Transfers." For the old district that is losing the employee, the information in Section A above holds true, in that coverage will be extended through the summer if they worked the last day of their contract and premiums are paid.

  If both Summer Transfer contract date rules are fulfilled and summer premiums have been paid, the employee will not experience a break in coverage. Coverage under the old district will stop on August 31st and coverage under the new district will begin on September 1st.

  If the contract employment date rules were not fulfilled, the employee is not considered a summer transfer and must enroll as a new employee in the Fall, subject to all new employment rules and deadlines.

- **Insurance Coordinator Responsibility of New Agency:**
  - **Notification:**
    The district to which the employee transferred (new district) is responsible for sending an Update Form, indicating "Summer Transfer" at the top, with an insurance effective date of 9/1. The district also has the option of compiling all summer transfer employees on a single list and mail or faxing them to DEI for processing.

  - Correcting New Employee to "Summer Transfer" Status:
    An employee who should have been classified as a summer transfer but his/her premiums were not deducted for the summer months will likely experience a break in coverage. Should this occur, the employee has a couple of options (see below). The same options also apply to an employee whose new school district did not realize he/she was a summer transfer and, as a result, the employee experienced a break in coverage when the new hire 1st day of the 2nd month waiting period was applied.

    The employee may choose
    - to back up coverage as early as his/her hire date under the new school district and pay the arrears either by personal check or through their first paycheck; or,
    - to leave the summer months un-covered due to lack of medical or pharmacy claims, and start his/her coverage either on August 1st or September 1st. Anytime an employee terminates coverage COBRA should be offered.

    When notifying DEI of an employee who should have been classified as a summer transfer instead of a new hire, please write "CORRECTION: Summer Transfer" on the Update Form or the Enrollment Application and indicate the

effective date of their coverage based on the options above. The three effective date possibilities are

1) the hire date,
2) August 1st or
3) September 1st.

C. Year Round Employees (all other Board of Education staff)

Year Round Employees will be processed in the same manner as a 12-month employee transferring during any other time of the year such as during February. Please refer to "New Employees, Transfers and Rehires" (Section 1) for details.

XII Coverage Terminations

A. Termination of employment

- **Health Insurance**

  - If an employee terminates employment between the 1st and the 15th of the month, their health insurance coverage will terminate on the 15th of the same month.
  - If an employee terminates employment between the 16th and the end of the month, their health insurance coverage will terminate on the last day of the same month.
    - **For example** – an employee terminates employment on March 5, health insurance coverage terminates on March 15. If an employee terminates employment on March 25, health insurance coverage terminates on March 31.

Employees are subject to the following provisions:

- The employee's contribution will be deducted automatically from the employee's check. In the event there is not enough money in the last paycheck to cover the premium, agencies should collect from the individual or deduct the remainder from the payout of vacation or compensatory pay.
- Employees who terminate employment before their benefits take effect are not eligible for those benefits and, therefore, not eligible for COBRA.
- The Insurance Coordinator **must** terminate the employee via the on-line system or submit an Update Form listing the employee's last day of employment. Terminations must be input within 10 days of the occurrence.
- The Insurance Coordinator must enter the termination information on Ceridian's WebQE to initiate Ceridian to mail COBRA information to the affected employee and dependents.
- Terminated employees who were enrolled in a cross-reference payment option **are** eligible for COBRA. You MUST enter the terminated employees in Ceridian's WebQE. This is a federal requirement and fines may be incurred if COBRA notification is not processed in a timely manner.

- **Flexible Benefits**

  Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs) end on the same day an employee terminates employment, regardless of when that occurs.

B. Procedures for the retirement systems

For all sections below: If the disability is due to End Stage Renal Disease (ESRD) or if ESRD is diagnosed before the age of 65, see Section F.

- **Medicare Eligible Retiree with Couple, Family or Parent Plus plan (NOT actively employed)**
  - Retiree becomes Medicare Eligible
    Plan terms end of month (day before Medicare eligible)
    - Currently enrolled dependents may apply (within 35 calendar days from Medicare Eligibility date) to take over plan with no break in coverage if dependents enroll timely.
  - Spouse/dependent (PH) who took over the plan above dies leaving dependent(s) on the plan
    - Plan terms end of the month following the date of death

NOTE: In both cases above, the Retiree (XH) is not deceased

- **Medicare Eligible Retiree with Single plan (NOT actively employed)**
  - Under 65 Retiree becomes Medicare Eligible due to disability or age; or 65 or older retiree becomes Medicare Eligible **(Has not returned to active employment with a KEHP affiliated agency)**
    - Plan terminates end of month (day before Medicare eligible)

      When retirees reach age 65, they will receive a letter stating whether or not they are Medicare eligible. Regardless of their Medicare enrollment status, retirees who have not returned to active employment who become eligible for Medicare are no longer eligible participants of the KEHP (See KRS 18A.225), EXCEPT in cases of End Stage Renal Disease. (See section F. for ESRD information). The retirement system must send a termination notice to DEI terminating the retiree due to Medicare eligibility. If the Medicare letter states that the retiree does not qualify for Medicare, the retirement system must submit the letter to DEI in order to show that the retiree is still qualified to remain on the Plan.

Note: Eligibility for partial benefits also constitutes Medicare eligibility. Although some retirees may choose to defer drawing benefits until a later date, they are still ineligible to participate in the KEHP and their KEHP coverage must be terminated.

- **Retirees 65 and Older Who Return To Work**

  - **Federal Medicare law dictates that retirees who are age 65 and older or Medicare eligible and who return to work with the Commonwealth and are eligible to participate in KEHP may not be eligible to participate in a plan that supplements that employee's Medicare coverage provided by a Kentucky retirement system.**

  - **Retirees who are Medicare eligible and actively employed** with a participating agency, may participate in KEHP or **may** be eligible to participate in a Kentucky retirement sponsored Medicare Supplement but not both. **These retirees must contact their retirement system to determine whether they are eligible for a Medicare supplement plan through a retirement system.**
    - KRS retirees should ask for a Health Care Counselor

  - Retirees 65 and older who are eligible for Medicare, actively employed and benefits eligible must be offered an opportunity to enroll in KEHP through their active employer. The Insurance Coordinator for the active employer shall furnish the retiree a copy of the Notice to Active Employees 65 and Over set forth in Appendix A.

    - **KRS or KTRS retirees 65 and older who are actively employed and are eligible for and elect to participate in a Medicare Supplemental plan offered by a Kentucky retirement system rather than KEHP, are NOT eligible for state funding through their active agency. These employees should waive coverage through KEHP and are not eligible for an HRA.**

  Retirees 65 and older who return to work may elect to participate in a Healthcare FSA account through their active employer and contribute their own money into that account.

1. **Deceased Retirees**

The deceased retiree's beneficiary (the individual designated by the retiree as his or her beneficiary, or filed with the retirement system) may apply to enroll in the health plan when he/she experiences a Qualifying Event that would allow the beneficiary to enroll (such as loss of other coverage) or during Open Enrollment.

- If a retiree's beneficiary is a dependent(s)/spouse on the plan they may "take over" the policy as the planholder. The retiree's dependent must elect the coverage within 35 days of the loss of coverage.
- If a retiree's beneficiary is not a current spouse or dependent on the plan, they must contact the retirement system within 35 days of the death of the retiree. The retirement system will determine eligibility dates. The death of the retiree in itself may not be a Qualifying Event that would allow the beneficiary to enroll in the plan.

  - If the retiree dies and has a Single plan:
    - Plan terms date of death

- If the retiree dies and has a Parent Plus, Couple or Family Plan
  - Plan terms end of the month. in which the date of death occurs
  - Current beneficiary may apply, within 35 calendar days from date of death to take over plan
- Beneficiary (PH) dies Single Coverage
  - Plan terms date of death
- Beneficiary (PH) with Dependents dies
  - Plan terms end of month in which the date of death occurs

The IC should submit an application to DEI with the new planholder's insurance elections.

C. Death of employee

New – Effective March 1, 2010

- **<u>Single Coverage</u>:**
  - **If the member dies between 1st - 15th of month, coverage ends on date of death and no premium is due.**
  - **If the member dies between the 16th and end of Month, coverage ends on date of death. The full month premium is due.**
- **Parent Plus, Couple or Family Coverage:**
  - **If the member dies, the dependent coverage will continue to the end of the month in which death occurs. The full month premium is due.**
  - **If the dependent dies and the death causes the plan level to change (i.e. from Family to Parent Plus, etc), the original level of coverage will continue to the end of the month in which the death occurred and the full month premium is due. The new level of coverage will begin the 1st of the next month and the new premium begins.**

Note: The process for administering the Qualifying Event of Death has not changed for FSA and HRA. Please refer to Chapter 3 for details.

At the time of death, the Insurance Coordinator should notify the family, in writing, of the following:

- Date the last paycheck will be issued;
- Contact information for the appropriate retirement system;
- Name and phone number of the Plan's administrator; and
- Additional employee payroll deductions and agency contacts.

You will also need to enter the Qualifying Event on Ceridian's WebQE.

See Qualifying Event of Death Chart in Appendix K.

D. Loss of dependent eligibility

Dependent children and/or spouses who become ineligible for coverage under the Plan (other than for attaining the limiting age) will be terminated at the end of the month

they cease to meet the dependency requirements, whether the 35 day requirement has been met or not.

Dependent children who become ineligible under the Plan due to attaining the limiting age will be terminated at the end of the calendar month in which the birthday occurs. For example, coverage for dependent children who turn 25 in May will terminate the end of May.

NOTE: If an employee has a dependent covered under their plan that is between 23 years of age and 25 years old, the employee **MUST** re-enroll that dependent every year beginning with the year in which they turn 24. Unless the dependent child continues to qualify as a Qualified Relative, the premium will be on a post-tax basis. If the dependent child is not enrolled, COBRA must be offered.

E. Employees and Dependent Spouses Age 65 and Over

An active employee age 65 or over or a dependent spouse age 65 or over and eligible for Medicare **is eligible for coverage through KEHP** under their active employer. If the employee is a retiree through a Kentucky sponsored retirement system they **may not be eligible for** a Medicare supplement plan offered through their retirement system. These employees should contact their retirement system to determine whether they are eligible for a plan through their retirement system. The Medicare eligible active employee is treated like any other employee and may elect coverage or waive coverage through KEHP. The return to work retiree is not eligible for an employer contribution and a contribution from a retirement system.

F. End Stage Renal Disease

Members who were diagnosed with End Stage Renal Disease (ESRD) before becoming Medicare eligible remain eligible for coverage under KEHP for the first 30 months of their Medicare eligibility. This rule applies whether or not the member has reached age 65.

XIII Retro Activity Related to Premiums

Any mid-year election change resulting in the termination of a covered person will be effective on the date as designated under the terms of the KEHP. Refunds will be restricted to the beginning of the current plan year to a maximum period of 2 months or 60 days, except in the event of the death, in the same Plan Year, of a covered person.

For specific information regarding refund requests, refer to Chapter 7, Premium Billing and Reconciliation.

XIV Retiree Eligibility

A Kentucky Retirement Systems (KRS)

KRS retirees who are not Medicare eligible and who have returned to active employment have the option to select coverage either through KRS or through the active employer.

KRS retirees who return to work may:

- **Enroll** in a KEHP health insurance plan through KRS and **waive** coverage through their employer but **not enroll in the stand-alone HRA**;
- **Waive** coverage with KRS (i.e. receive no retirement insurance benefit) and **enroll** in a health insurance plan (including Commonwealth Maximum Choice) through their employer; or
- **Waive** coverage with KRS (i.e. receive no retirement insurance benefit) and **waive** coverage through their employer and **enroll in a stand-alone HRA**.

B. Kentucky Teachers' Retirement System (KTRS)

KTRS retirees who have returned to active employment must select coverage through the active employer.

KTRS retirees who return to work may:

- **Waive** coverage with KTRS (i.e. receive no retirement insurance benefit) and **enroll** in a health insurance plan (including Commonwealth Maximum Choice) through their employer; **or**
- **Waive** coverage with KTRS (i.e. receive no retirement insurance benefit) and **waive** KEHP coverage through their employer and enroll **in the stand-alone HRA** through their employer.

C Retirees 65 and older who return to work

Retirees 65 and older who return to work as an active employee must be offered an opportunity to enroll in KEHP through their active employer. The Insurance Coordinator for the active employer shall furnish the retiree a copy of the Notice to Active Employees 65 and Over set forth in Appendix A. If the retiree elects KEHP coverage, they shall receive an employer contribution towards KEHP coverage through their active employer.

A retiree 65 or older who returns to work may elect to participate in a Healthcare FSA account through their active employer.

D. Spouses Of Retirees

Spouses of retirees, who are covered under the retiree's plan and who are actively employed, are not eligible to waive coverage and receive the employer contribution into an HRA due to KRS 18A.225 (12), which reads as follows:

> *Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems **shall not** be eligible to*

receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year. (Emphasis added).

GENERAL ADMINISTRATION

I Appeal Procedures

For additional details regarding appeals, please refer to the Summary Plan Descriptions (SPD)

A. Appeals to the Third Party Administrator (TPA)

Humana, the TPA for the KEHP, has a two-level internal appeals procedure. Appeals to the TPA include, but are not limited to, medical claims rejections, medical claims adjudication, medical prior authorization denials, medical provider networks, etc.

B. Appeals to the Pharmacy Benefits Manager (PBM)

Express Scripts, Inc. (ESI), the PBM for the KEHP, has a one-level internal appeals procedure. Appeals to the PBM include, but are not limited to: pharmacy prior authorizations, pharmacy step therapy, pharmacy Quantity Level Limit (QLL), pharmacy refill frequency, pharmacy provider networks, etc.

C. Appeals to the Kentucky Department of Insurance (DOI)

The DOI will be available to provide coverage denial reviews after KEHP members have exhausted the TPA and/or the PBM's internal levels of appeals.

D. External Review Appeals

KEHP members have the right to appeal medical necessity determinations to an independent review entity after the TPA and/or the PBM's internal levels of appeals. Request for External Reviews must be sent to the Kentucky Department of Insurance.

E. Grievances and Appeals to the KEHP

- Eligibility & Enrollment Grievance Committee

  Employees who are dissatisfied with a decision regarding enrollment or termination in the KEHP may file a grievance to the KEHP's Grievance Committee. Employees must file grievances no later than 30 calendar days

from the event or notice of the decision being protested. Grievances must be filed in writing to:

Personnel Cabinet
Department of Employee Insurance
Attention: Grievance Committee
501 High Street, 2nd Floor
Frankfort, KY 40601

Grievances must include ALL of the following items:

- Employee's name and Social Security Number, and agency name;
- A description of the issue(s) disputed by the employee;
- A statement of the resolution requested by the employee;
- All other relevant information; and
- All supporting documentation.

Grievances without all necessary information will be returned without review.

A written response will be mailed to the employee and to the agency's health Insurance Coordinator stating the decision of the Committee.

The Committee will not review a second request **unless** additional relevant facts are provided.

NOTE: Non-covered benefits or non-covered prescriptions are not appealable to the Grievance Committee.

NOTE: The Grievance Committee will only review grievances regarding enrollment and/or eligibility.

F. Administrative Appeals Committee

Members who are dissatisfied with a formulary change decision may file an appeal to the KEHP's Administrative Appeals Committee. Members must file the appeal no later than 60 days from the date of the notice of the formulary change.

Appeals must include ALL of the following items:

- Member's name and Social Security Number, and agency name;
- A description of the formulary change being disputed by the member;
- A physician's statement which states that the member's physician is of the opinion that the member continue to take the drug as before the formulary change;
- All other relevant information; and
- All supporting documentation.

Appeals must be filed in writing to:

Personnel Cabinet
Department of Employee Insurance
Attention: Administrative Appeals Committee
501 High Street, 2nd Floor
Frankfort, KY 40601

II Fraud

If the TPA, the PBM, and/or the KEHP believe that any fraudulent activity has occurred, they are authorized to investigate and resolve issues arising from the fraudulent activity. Any person who knowingly, and with the intent to defraud any insurance agency or other person, files an application for insurance containing any incorrect information or a forged or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. Any material misrepresentation may be used to reduce or deny a claim or to terminate coverage.

III Double Dipping

Retirees Under 65 Who Return to Work

An employee under 65 (or their spouse) who is eligible for and participates in KEHP as a retiree (or as the spouse or beneficiary of a retiree) **and** as an active employee (or spouses), is permitted to have only one KEHP contribution. They are not allowed to receive a contribution as a retiree and a second contribution as an employee. Specifically, KRS 18A.225 (12) addresses it as follows:

> "Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year."

Hazardous Duty Retirees

- When hazardous-duty retiree receives a fully paid KEHP family plan from KRS and the spouse of the hazardous-duty retiree is an active employee. The spouse can:

The spouse has the following options,

- Elect to be covered under a KEHP single plan through the active employer (and stop coverage under their spouse's plan).
- Elect to remain covered under the KEHP family plan through their hazardous duty retiree spouse. If the active employee elects coverage under the hazardous-duty retiree's KEHP family plan, he/she will be

allowed to waive but will not receive an active employer contribution into an HRA.
- Elect to cross-reference with their hazardous duty retiree spouse.

KRS retirees who have returned to active employment have the option to select coverage through KRS or through their active employer. Refer to Chapter 1, Section XIV, Retiree Eligibility, for additional information. For specific details contact KRS.

KTRS retirees who have returned to active employment must select KEHP coverage through the active employer. Refer to Chapter 1, Section XIV, Retiree Eligibility, for additional information. For specific details contact KTRS.

Superintendent With a Working Spouse Eligible to Participate in KEHP

If the Superintendent's contract specifies that the school district pays 100% of the KEHP plan (both employer and employee portions) the spouse may continue to be listed as a dependent on the superintendents' plan and still be eligible to waive and enroll in an HRA.

Spouse Eligible as a Planholder and Covered on Plan of Their Spouse:

A spouse who gains eligibility as a planholder under KEHP has the following options:
- Remain covered under their spouse's KEHP plan (couple or family) and waive coverage with NO HRA under their active employer.
- Cross reference with spouse
- Drop coverage under their spouses plan and either choose coverage under their own KEHP health plan or a stand-alone HRA

The newly eligible spouse **can not** be covered under their spouse's plan and a KEHP stand-alone HRA as their own planholder.

IV Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is legislation enacted by the federal government to: ensure health insurance portability; reduce health care fraud and abuse; guarantee the integrity and confidentiality of health information; and improve the operations of the health care system.

A. Privacy

HIPAA specifically addresses protecting the privacy of protected health information (PHI). The government has established limitations on the sharing of PHI.

PHI is medical and demographic information that is identifiable to a specific person. Examples of PHI are an individual's address, gender, Social Security Number, date of birth, diagnosis or claims history.

B. What is DEI doing to comply with HIPAA?

Due to compliance requirements, DEI implemented several changes designed to protect personal health information used in electronic mail. These changes are applicable to all programs.

When a member's information is being transmitted via electronic mail there are two competing interests: (1) The plan holder has an expectation that the use of PHI is limited to the minimum necessary to carry out the purpose of the communication; and (2) The employees involved in the communication have an interest in sharing the maximum amount of information permissible to ensure the purpose/needs of the communication is/are met.

DEI does not maintain information regarding employee's specific medical or health conditions but does maintain demographic PHI and other information that is necessary for determining eligibility and enrollment in the KEHP.

The DEI's HIPAA Privacy Notice is located in the KEHP Handbook or Benefits Selection Guide or online at www.kehp.ky.gov.

DEI's HIPAA Privacy and Security Polices are located on-line at http://personnel.ky.gov/dei/hipaa.htm.

In addition to those concerns, electronic mail is considered a public document and is subject to open records requests. One of DEI's concerns is that PHI transmitted via electronic mail may be inadvertently disclosed to the public through an open records request.

Based on these concerns, DEI implemented the following procedures for transmitting employee information (PHI or personally identifiable information) to our vendors/third-party administrators (TPA), Insurance Coordinators, Enrollment Specialists, Business Associates, and Billing Specialists within DEI via electronic mail:

- Use encrypted email (ENTRUST or a similar encryption product) to transmit any and all PHI. In the subject line of the encrypted email use the word "Confidential."

  Using the word "Confidential" in the subject line ensures that the Commonwealth Office of Technology (COT) can identify all electronic mail to and from this office containing personally identifiable information. If an open records request is made that would include any electronic mail marked *confidential*, the request will be forwarded to DEI so that the requested electronic mail may be edited before complying.

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If your agency does not use any encryption software and you need to communicate an employee's information to DEI **you must fax the information (using a cover sheet that identifies the information as "*confidential health information*"). DO NOT send any PHI information via email if you do not have encryption software.** When DEI faxes information to an IC they will first call to verify that the IC is available to receive the fax. After receiving the fax the IC must call DEI to acknowledge receipt of the fax.

- If a member of the KEHP wishes to allow a spouse, dependent or any other individual to make inquiries regarding the member's health insurance or Flexible Benefit Accounts, they must complete an Authorization for Disclosure Form. This form allows DEI to disclose PHI to the authorized individual. The authorization forms can be found on DEI's Web site. Employees may also contact DEI's Member Services Branch to request a copy of the form.

  Members will need to contact their TPA/PBM for information relating to payment of claims and which benefits are covered under their health plan. If the member needs to have information disclosed from the TPA/PBM to someone other than themselves, the TPA/PBM may require them to complete an Authorization for Disclosure Form. DEI's Authorization for Disclosure Form will not be accepted by the TPA/PBM. The member will be required to abide by the TPA/PBM's policies and procedures concerning release of their PHI.

V Health Insurance/Prescription I.D. Cards

For privacy reasons, the planholder's Social Security Number is not printed on the I.D. cards.

Employees will receive their I. D. card(s) within 14 days of receipt of enrollment information by the TPA. Employees who have not received their I.D. card and need proof of coverage may go to www.Humana.com and follow these steps:

- Click on the section called *Members Site;*
- Go to *Quick Links* located at the bottom right hand corner;
- Click on *View ID Card;*
- Enter the requested information under *Commercial Group Health Members;*
- Click on *View ID Card*;
- Print the employee's temporary card.

Employees may request additional I.D. cards by calling 1-877-KYSPIRIT (1-877-597-7474).

NOTE: Even though the KEHP has two administrators (Humana for medical benefits and Express Scripts, Inc. for pharmacy benefits), employees will only receive one I.D. card.

QUALIFYING EVENTS

I Section 125 Cafeteria Plan

The Kentucky Employees Health Plan (KEHP) is provided through a Section 125 plan, this allows employees to pay for their health insurance premiums with pre-tax monies. Section 125 plans are federally regulated. Federal guidelines state that if employees' health insurance is offered through a Section 125 plan, they cannot make a change in their health insurance options outside of the Open Enrollment period unless they experience a permitted election change (DEI refers to those permitted election changes as Qualifying Events). Permitted election changes are also governed by federal guidelines.

II General Information Regarding Qualifying Events

The following information relates to insurance that is not employer-sponsored group health coverage

The following are recognized as valid health coverage:

- Individual health insurance;
- Short-term, limited-duration insurance also known as "gap" insurance; and
- Student health insurance.

In order to enroll in the KEHP, the individual must have experienced one of the following events which caused them to lose coverage from one of the health plans listed above:

- Maximum benefits level is reached;
- Insurance agency cancels policy (other than for non-payment);
- Coverage was provided under COBRA and COBRA has expired;
- Coverage was non-COBRA and the coverage terminated due to loss of eligibility for coverage (including but not limited to: legal separation, divorce, end of dependent status, death of an employee, termination of employment, reduction in hours) or employer contributions for coverage were terminated; or
- Plan no longer offers benefits for a group of individuals.

The following events will NOT be recognized as loss of other coverage with special enrollment rights because there has not been a change in eligibility:

- Non-payment - choosing to stop payment of a plan for any reason;
- Non-renewal - choosing to stop renewal of a plan for any reason;
- Cancellation of coverage by policy holder for policy holder;
- Cancellation of coverage by policy holder for dependent;
- Increase in cost of coverage; or
- Reduction of contributions or level of benefits.

The following types of insurance are NOT considered other coverage:

- Coverage only for accident or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance;
- Workers compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- VA Benefits
- Coverage for on-site medical clinics; or
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Note: Gaining KCHIP is not a permitted Qualifying Event to drop coverage. Gaining coverage for **KCHIP or Medicaid premium assistance** is a Qualifying Event to add coverage.

III Changes in Coverage during the Open Enrollment Period

All changes are permitted during Open Enrollment with the following exception:

- Employees cannot drop dependent children for whom they are required by an administrative order to provide coverage if enforcement of the order is directed to the employer. This includes National Medical Support Orders.
- Employees cannot add a previously un-covered disabled dependent (DD) who is over the age limit.

IV Qualifying Events

The following pages reflect the mid-year election changes permitted in health insurance for the entire group and the changes permitted in the Healthcare FSA, Dependent Care FSA and Waiver HRA.

The following pages describe the election changes that a cafeteria plan can permit employees to make during a period of coverage under the cafeteria plan regulations, as amended. This chart reflects our views of permitted election changes, which are

adopted for the 2010 Plan Year and each Plan Year thereafter unless amended. The only required mid-year election changes are those related to loss of eligibility (death, divorce, loss of dependency and age and HIPAA Special Enrollment Rights.)

Note: The Waiver HRA row is intended for use by employees who are currently waiving their health insurance and who experience a corresponding Qualifying Event under the *Event*. The Waiver HRA row states what employees are allowed to do with their stand-alone HRA if they experience that Qualifying Event.

Note: The information relating to Qualifying Events for a Healthcare FSA and Dependent Care FSA are for use with agencies that have their Flexible Benefits Program with the KEHP (i.e., state agencies, local school boards and certain quasi governmental agencies.)

V General Guidelines Regarding Qualifying Events

After the Open Enrollment period, employees must experience a Qualifying Event (as listed on the following pages) to add or drop dependents or, under appropriate circumstances, make other permitted changes.

A Signature Dates

- Most Qualifying Events have a signature deadline of 35 calendar days from the event date. However, some have a signature deadline of 60 calendar days from the event date. It is important to know the signature deadlines for all Qualifying Events. Most effective dates are the first day of the month following the signature date. For purposes of determining the 35 or 60 calendar day deadline for Qualifying Events, the Group Health Insurance (GHI) system counts 35 or 60 calendar days beginning on the day after the Qualifying Event.

- A request for a change, due to a Qualifying Event, may not be signed before the event takes place; except for the following:
  - Loss of other health coverage;
  - Gaining other group coverage;
  - Entitlement to Medicare; and
  - Spouse's different open enrollment period.

- **Qualifying Events that Occur During LWOP**
  - Employees on LWOP who experience a Qualifying Event must follow the same Qualifying Event rules as other employees. However, they must request the mid-year election change within 35 days from the return to work date.

IC Take Note: **The timing of the signature date is critical. Have your members complete and sign the request for QE before the signature deadline. They do NOT have to wait for the supporting documentation to sign the request.**

B. Effective Dates

- In any case, a requested change due to a Qualifying Event will not be effective prior to the event taking place. To apply this rule, consider the following:
    - If the Qualifying Event date is the first of the month, the employees may pre-sign during the previous month. For example, if loss of coverage occurs on April 1, the employee may sign the application or Dependent Add Form during the month of March. The effective date of the change will be April 1.
    - If the Qualifying Event date is any other day of the month, the employee may pre-sign during that month only. For example, if loss of coverage occurs on April 18, the employee may sign the application or Dependent Add Form during the month of April. The effective date of the change will be May 1.

- **Qualifying Events that Occur During LWOP**
    - The same rules as defined in the Returning from LWOP section will be applied to determine the effective date of coverage.

C Event

- The Qualifying Event date is the date the event takes place. It is not the date the employee or dependent is notified of the event. DEI will accept notification date only for Entitlement to CHAMPVA, TRICARE, and governmental programs such as Medicare and Medicaid.

Note: Incarceration:

- Incarceration of Spouse – Does not qualify as a QE for gain or loss of other coverage. The spouse must remain covered on the member's plan.
- Incarceration of Dependent – Dependent losses **eligibility as a dependent** and may qualify to be added or dropped on an eligibility basis. This is not a QE.

D Smoking Status Change

Employees may request a change in their smoking status outside of Open Enrollment. They will be required to provide certification (such as completion of a smoking cessation program, statement from their doctor, etc.) with the required Non-smoking Affidavit. The change to their smoking status will be limited to the smoker contributions. This change does not create a Qualifying Event to allow other changes to their plan. The change will be limited to the effective date with no retroactive premium adjustments. Smoking status may **not** be changed due to:

- Employee experiencing a Qualifying Event;
- Employee experiencing a break in service (employment) of 0-10 days.

E Supporting Documentation

Throughout the following pages we have indicated that certain Qualifying Events require supporting documentation. However, the Department of Employee Insurance reserves the right to request additional supporting documentation for any and all Qualifying Events.

VI Change of Status Events

Marriage (gain Spouse)

These qualifying mid-year election changes are permitted when an employee gets married.

Health Insurance Coverage	• Employee may add self and/or spouse and/or dependents, including tag-alongs. Member may make plan and/or option changes if adding dependents to plan. • Employee may drop self/dependents if person gains coverage under spouse's plan. However, employees will **NOT** be able to redirect the employer contribution to a Waiver HRA. If dropping dependents the employee may change plan options.
Healthcare FSA	• Employee may enroll or increase election • Employee may decrease employee election if family members become covered under spouse's health plan
Dependent Care FSA	• Employee may enroll or increase election if marriage increases dependent care expenses • Employee may terminate or decrease election if family elects dependent care assistance under spouse's plan or marriage decreases dependent care expenses
Waiver HRA	• Employee may terminate election and redirect the state contribution to health insurance.

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - If adding – none.
   - If dropping due to gaining other group health insurance coverage –
     - Letter from employer, on employer's letterhead, identifying the coverage begin date and the person(s) covered by the policy; or
     - Copy of new health insurance ID card(s) for each covered person, stating the coverage begin date.

2. **Forms to use:**
   - If enrolling – Enrollment Application or FSA Qualifying Event Change Form
   - If adding dependents – Dependent Add Form

- If adding dependents with plan and/or option changes – Enrollment Application
- If dropping dependents – Dependent Drop Form

3. Effective Date:

- If adding – first day of the month following the employee's signature on the application, Dependent Add Form or Flexible Spending Qualifying Event Change Form
- If dropping – end of the month of the employee's signature on the Dependent Drop Form
- If enrolling/increasing FSA – first day of the month following the employee's signature date. If terminating/decreasing FSA – end of the month of the employee's signature date.

4. Deadline:

- You must complete the appropriate paperwork within 35 calendar days from the event date.

Note: The event date to **add** dependents is the date of marriage. The event date to **drop** dependents is the date they gained other group health insurance coverage under the spouse's plan.

Note: Marriage is not a Qualifying Event to simply change plan options (i.e. an employee getting married cannot change from the Single Commonwealth Optimum PPO to Single Commonwealth Capitol Choice).

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Divorce, legal separation or annulment (Loss of Spouse)

These qualifying mid-year election changes are permitted when an employee gets a divorce, legal separation or annulment.

Health Insurance Coverage	• Employee may add self and dependents if person loses coverage under spouse's plan. • Employee may drop spouse; also drop family members added to former spouse's plan • Drop dependent children if they cease to meet the eligibility requirements under the KEHP (i.e. former spouse's children are no longer eligible) • Employee may change plan options, if dropping spouse or dependents.
Healthcare FSA	• Employee may enroll or increase election if event causes loss of coverage under spouse's health plan • Employee may terminate or decrease election
Dependent Care FSA	• Employee may enroll or increase election if event increases dependent care expenses or causes loss of coverage under spouse's plan • Employee may terminate or decrease election if event decreases dependent care expenses
Waiver HRA	• Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - If adding –
     - HIPAA Creditable Coverage;
     - Letter from employer/previous employer, on employer letterhead, identifying the coverage termination date and the person(s) covered under the policy;
     - Letter from insurance agency identifying the type of coverage, the reason for termination and the person(s) covered under the policy; or
     - Termination letter from governmental agency under which previous coverage was held.
   - If dropping
     - Divorce decree signed by a judge and date-stamped "filed" or "entered";
     - Legal separation papers signed by a judge and date-stamped "filed" or "entered"; or
     - Annulment papers signed by a judge and date-stamped "filed" or "entered".

2. **Forms to use:**
   - If enrolling – KEHP Enrollment Application; or FSA Qualifying Event Change Form

- If adding dependents – Dependent Add Form

- If adding or dropping dependents and requesting plan changes – Enrollment Application
- If dropping dependents – Dependent Drop Form

3. **Effective Date:**
   - If adding – first day of the month following the employee's signature on the application or Dependent Add Form
   - If dropping spouse/children – end of the month of the divorce, legal separation or annulment
   - If dropping dependent children that were <u>added to former spouse's group plan</u> - end of the month of the employee's signature on the Dependent Drop Form
   - If enrolling/increasing FSA – first day of the month following the employee's signature date.
   - If terminating/decreasing FSA – end of the month from the employee's signature date.
   - The requested change will not be effective prior to the Qualifying Event date.

4. **Deadline:**
   - You must complete the appropriate paperwork within 35 calendar days from the event date. This Qualifying Event makes the former spouse ineligible to participate in the KEHP; therefore, the former spouse must be dropped from the plan at the end of the month of ineligibility, even if the 35 day deadline is not met.
   - The Enrollment Application or Dependent Add Form may be signed by the employee prior to the loss of coverage.

Note: When enrolling themselves or adding dependents, the event date is the date of loss of coverage. If there is no loss of coverage, the date the divorce decree is entered by the court is the event date for divorce.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Spouse's death

These qualifying mid-year election changes are permitted when an employee's spouse dies.

Health Insurance Coverage	• Employee may add self and their dependent children, including tag-alongs that have lost coverage under the spouse's plan. • Must drop spouse from plan (if covered) • Employee may change plan options when adding/dropping spouse or dependent
Healthcare FSA	• Employee may enroll or increase election if death causes loss of coverage under spouse's health plan • Employee may decrease employee election
Dependent Care FSA	• Employee may enroll or increase election if death causes loss of coverage under spouse's plan or increases dependent care expenses • Employee may terminate or decrease election if death decreases dependent care expenses
Waiver HRA	• Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan.

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - If adding themselves and their dependent child(ren) if the event causes loss of other coverage –
     - HIPAA Creditable Coverage;
     - Letter from employer/previous employer, on employer letterhead, identifying the coverage termination date and the person(s) covered under the policy;
     - Letter from insurance agency identifying the type of coverage, the reason for termination and the person(s) covered under the policy; or
     - Termination letter from governmental agency under which previous coverage was held.
   - To drop the deceased spouse – none.

2. **Forms to use:**
   - If enrolling – KEHP Enrollment Application or FSA Qualifying Event Change Form
   - If adding dependents – Dependent Add Form
   - If adding/dropping dependents and requesting plan option changes – Enrollment Application
   - If dropping dependents – Dependent Drop Form

3. **Effective Date:**
   - If adding – first day of the month following the employee's signature on the

application or Dependent Add Form

- The spouse's coverage will end at the end of the month of the spouse's date of death. The new plan will be effective on the first day of the following month.
- If enrolling/increasing FSA – first day of the month following the employee's signature date.
- If terminating or decreasing HC FSA – end of the month from the employee's signature date.
- If terminating/decreasing DC FSA - end of the month from the employee's signature date.
- See QE of Death Chart Appendix K

5. Possible refund for FSA

- Refund only if member paid for complete month and died before the 15th of the month.

6. Deadline:

- If adding, you must complete the appropriate paperwork within 35 calendar days from the event date.
- If dropping – upon notification of the spouse's death. The deceased spouse's coverage will be terminated even if the 35 day deadline is not met.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Birth/Adoption/Placement for Adoption

These qualifying mid-year election changes are permitted when a birth, adoption, or placement for adoption occurs.

NOTE: To add grandchildren, employees must use the Qualifying Event "judgment, decree or administrative order relating to health coverage for the child".

Health Insurance Coverage	• Employee may add self and/or spouse and/or other dependents, including tag-alongs. • Employee may change plan options when adding spouse or dependent
Healthcare FSA	• Employee may enroll or increase election
Dependent Care FSA	• Employee may enroll or increase election if employee has greater dependent care expenses
Waiver HRA	• Employee may terminate election and redirect the state contribution to health insurance.

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - For birth - none
   - For adoption or placement for adoption:
     - Placement papers from the Cabinet for Health and Family Services;
     - Signed and date-stamped "filed" papers from the court;
     - Letter from adoption agency on letterhead;
     - Legal document from a US court; or
     - Official document translated into English and/or copy of the child's visa-if foreign adoption.

2. **Forms to use:**
   - If enrolling – KEHP Enrollment Application FSA Qualifying Event Change Form
   - If adding dependents – Dependent Add Form
   - If adding dependents and requesting plan changes – Enrollment Application

3. **Effective Date:**
   - For birth- the child's date of birth
   - For adoption – the child's adoption date
   - For placement (including placement by judgment and court orders) – the child's placement date.
   - If enrolling/increasing FSA – first day of the month following the employee's signature date.

4. Deadline:

- If adding only the newborn child(ren) or newly adopted or placed for adoption child(ren) –60 calendar days from the child's date of birth, the child's adoption date or the child's placement date.
- If adding only the new born child(ren) or newly adopted or placed for adoption child(ren) PLUS any other dependents (tag-alongs) –35 calendar days from the child's date of birth, the child's adoption date or the child's placement date.

5. Other:

- If the birth, adoption or placement for adoption changes the employee from a Single or Waiver HRA to a Parent Plus or family and the event date is between the 1st and the 15th, the member pays the new Parent Plus or Family Plan premium for the whole month.
- If the birth, adoption or placement for adoption changes the employee from a Single or Waiver HRA to a Parent Plus or family and the event date is between the 16th and the last day of the month, the member pays the new Parent Plus or Family Plan premium for one half of the month.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Spouse or dependent loses other employer-sponsored health coverage (termination of employment, strike or lockout, commencement of unpaid leave, loss of eligibility under the employer's plan, etc.)

These qualifying mid-year election changes are permitted when a spouse or dependent loses other employer-sponsored health coverage.

Health Insurance Coverage	• Employee may add self, spouse, and/or dependents, including tag-alongs, if event causes loss of coverage under spouse's or dependent's health plan • Employee may change plan options when adding/dropping spouse or dependent
Healthcare FSA	• Employee may enroll or increase election if event causes loss of coverage under spouse's or dependent's health plan
Dependent Care FSA	• Employee may enroll or increase election if event causes loss of eligibility for coverage under spouse's dependent care assistance plan; or • Employee may terminate or decrease election if event decreases dependent care expenses
Waiver HRA	• Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - HIPAA certificate from prior carrier; or
   - Letter from employer/previous employer, on letterhead, identifying the coverage termination date and the person(s) covered under the policy; or
   - Letter from insurance agency identifying the type of coverage, the reason for termination and the person(s) covered under the policy; or
   - Termination letter from governmental agency under which previous coverage was held.

COBRA:

Some employers may offer a few months of COBRA payments to terminated employees as part of a severance package. It is important to remind your employees that the end of the employer-paid COBRA coverage is NOT a Qualifying Event that would allow enrollment in the KEHP, as the COBRA continuation coverage period has not been exhausted. Only Expiration of COBRA is considered loss of other coverage.

NOTE: The ending of a person's COBRA subsidy under the American Recovery and Reinvestment Tax Act DOES NOT constitute a Qualifying Event.

2. **Forms to use:**
   - If enrolling – KEHP Enrollment Application or FSA Qualifying Event Change Form
   - If adding dependents – Dependent Add Form
   - If dropping dependents – Dependent Drop Form
   - If adding/dropping dependents with plan election changes – Enrollment Application

3. **Effective Date:**
   - The first day of the month following the employee's signature date on the application or Dependent Add Form.
   - The requested change will not be effective prior to the Qualifying Event date.
   - If enrolling/increasing FSA – first day of the month following the employee's signature date.
   - If terminating/decreasing FSA – end of the month from the employee's signature date.

4. **Deadline:**
   - Thirty-five (35) calendar days from the Qualifying Event date. The Qualifying Event date is the date the added members lose coverage under the employer-sponsored group health plan.
   - The application or Dependent Add Form may be signed by the employee prior to the loss of coverage.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Spouse or dependent gains other employer-sponsored group health coverage (by commencing employment, returning to work after a strike or lockout, returning form unpaid leave, gaining eligibility under the employer's plan, etc)

These qualifying mid-year election changes are permitted when a spouse or dependent gains other employer-sponsored group health coverage.

Health Insurance Coverage	• Employee may drop self, spouse, or dependent(s) who become covered under spouse's or dependent's plan (coverage gained must be employer-sponsored group coverage) • Employee may change plan options when dropping spouse or dependent
Healthcare FSA	• Employee may decrease or terminate election if family becomes covered under health plan of spouse or dependent
Dependent Care FSA	• Employee may enroll or increase election if event increases dependent care expenses; OR • Employee may terminate or decrease election if family becomes covered under spouse's dependent care assistance plan
Waiver HRA	• Does not apply - No change allowed

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - Letter from employer, on employer's letterhead, identifying the coverage begin date and the person(s) covered by the policy; OR
   - Copy of new health insurance ID card(s) for each covered person, stating the coverage begin date.

2. **Forms to use:**
   - If dropping dependents – Dependent Drop Form
   - If terminating plan – If Member gains other coverage – KEHP Enrollment Application showing waiver NO HRA.
   - If changing plans – Health Insurance Application
   - If changing FSA benefits - FSA Qualifying Event Update Form

3. **Effective Date:**
   - If dropping – end of the month of the employee's signature on the Dependent Drop Form
   - The requested change will not be effective prior to the Qualifying Event date.
   - If terminated/decreasing FSA – end of the month from the employee's signature date.

4. **Deadline:**

- You must complete the appropriate paperwork within 35 calendar days from the event date. The Qualifying Event date is the date the dropped members gain coverage under the spouse or dependent's employer-sponsored group health plan.

Note: The paperwork may be signed by the employee prior to gaining coverage.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Dependent re-establishes Plan eligibility requirements

These qualifying mid-year election changes are permitted.

Health Insurance Coverage	• Employee may add dependent who satisfies plan eligibility requirement • Employee may change plan options when adding a spouse or dependent
Healthcare FSA	• Employee may enroll or increase election
Dependent Care FSA	• Employee may enroll or increase election if event increases dependent care expenses
Waiver HRA	• Does not apply • No change allowed

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - The employee must provide the reason the dependent is re-establishing his/her eligibility under the guidelines of the KEHP
   - At the discretion of the DEI, the employee may be requested to provide supporting documentation

2. **Forms to use:**
   - If adding dependents – Dependent Add Form
   - If enrolling or increasing FSA Deductions - FSA Qualifying Event Update Form
   - If adding dependent and changing option – Health Insurance Application

3. **Effective Date:**
   - First day of the month following the employee's signature date on the appropriate paperwork.

4. **Deadline:**
   - You must complete the appropriate paperwork within 35 calendar days from the event date.

Note: This is not a Qualifying Event to add tag-alongs – only the dependent that has re-established eligibility may be added.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Change in Residence

These qualifying mid-year election changes are permitted.

Health Insurance Coverage	• No changes allowed
Healthcare FSA	• No changes allowed
Dependent Care FSA	• Employee may make a corresponding election change if the child care provider changes
Waiver HRA	• Does not apply • No change allowed

Important Things to Know About Making An Election Change Request For This Event

1. **Forms to use:**
   - FSA Qualifying Event Change Form

2. **Effective Date:**
   - First day of the month following the employee's signature date.

3. **Deadline:**
   - You must complete the appropriate paperwork within 35 calendar days from the event date.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

VII HIPAA Special Enrollment Rights Act of 1996

Loss of other group health insurance coverage or health insurance coverage that entitles employee or family member to be enrolled under HIPAA Special Enrollment Rights

These qualifying mid-year election changes are permitted.

Health Insurance Coverage	• Employee may add self and/or spouse and/or their dependents, including tag-alongs, if the event causes a loss of coverage under another group, individual, "gap" or student health plan (See Qualifying Events, Section II for more information regarding other valid coverage) • Employee may change plan options when adding dependent/spouse.
Healthcare FSA	• Employee may enroll, increase election, or decrease election.
Dependent Care FSA	• Employee may enroll, increase election, or decrease election
Waiver HRA	• Employee may terminate election and redirect the state contribution to health insurance

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - HIPAA certificate from prior carriers; or
   - Letter from employer/previous employers, on letterhead, identifying the coverage termination date and the person(s) covered under the policy; or
   - Letter from insurance agency identifying the type of coverage, the reason for termination and the person(s) covered under the policy; or
   - Termination letter from governmental agency under which previous coverage was held.

2. **Forms to use:**
   - If enrolling – KEHP Enrollment Application
   - If adding dependents – Dependent Add Form
   - If adding/dropping dependents and requesting plan changes – New Application
   - If enrolling or increasing FSA elections - FSA Qualifying Event Change Form

3. **Effective Date:**
   - First day of the month following the employee's signature date on the appropriate paperwork.

- The requested change will not be effective prior to the Qualifying Event date.

4. Deadline:

- For loss of coverage (except Medicaid or KCHIP) you must complete the appropriate paperwork within 35 calendar days from the event date.
- For loss of Medicaid or KCHIP coverage, you must complete the appropriate paperwork within 60 calendar days from the event date.
- The application or Dependent Add Form may be signed by the employee prior to the loss of coverage.

COBRA:

Some employers may offer a few months of COBRA payments to terminated employees as part of a severance package. It is important to remind your employees that the end of the employer-paid COBRA coverage is NOT a Qualifying Event that would allow enrollment in the KEHP, as the COBRA continuation coverage period has not been exhausted. Only Expiration of COBRA is considered loss of other coverage.

NOTE: The ending of a person's COBRA subsidy under the American Recovery and Reinvestment Tax Act DOES NOT constitute a Qualifying Event.

HIPAA:

The Health Insurance Portability and Accountability Act (HIPAA) was amended to provide new rights and protections for participants and beneficiaries in group health plans. HIPAA contains protections for both health coverage offered in connection with employment (group health plans) and for individual insurance policies sold by insurance companies (individual policies).

Therefore, an employee (or dependent of a covered employee) who has experienced a loss of group health insurance coverage or has experienced a loss of other health insurance may join the Plan.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

VIII Other Events

Judgment, decree, or administrative order relating to health coverage for child (including grandchildren)

Health Insurance Coverage	▪ Add children to an existing plan if required by a court order, placement papers from the Cabinet for Health and Family Services, or if legal guardianship has been awarded; ▪ Add a grandchild – only if legal guardianship or custody has been awarded; ▪ Add themselves if they have previously waived coverage and the order stipulates to add child to the employees' plan offered through the employer. Upon receipt of an administrative order, the employer must enroll the child on the plan. The employees are responsible for full premiums due and may NOT redirect HRA contribution; or ▪ Drop children if the order stipulates that coverage is to be provided by the other parent; • Employee may change their plan options if adding dependents.
Healthcare FSA	• Employee may enroll or increase election if order requires employee to provide child's health coverage
Dependent Care FSA	• No change allowed
Waiver HRA	• Employee may terminate the employer contribution but may NOT redirect the employer contribution to health insurance coverage.

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - Filed and dated court decree; or
   - Agency administrative order; or
   - National Medical Support Notice

2. **Forms to use:**
   - If enrolling – Enrollment Application
   - If adding dependents – Dependent Add Form
   - If adding/dropping dependents and requesting plan changes – Enrollment Application
   - If enrolling or increasing Dependent Care FSA - FSA Qualifying Event Change Form

3. Effective Date:

- If adding a child at the employee's request (including grandchildren), the effective date is the first day of the month following the employee's signature on the application or Dependent Add Form;
- If adding a child and employee's consent to enroll the child is not needed (as in the case of a National Medical Support Notice directed to the employer), the effective date is the first day of the month following the date of the administrative order or notice;
- If dropping a child upon expiration of an order, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements;
- If dropping a child upon receipt of a new order releasing the employee from providing coverage for the child, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements.
- If dropping a child who is on the plan due to a National Medical Support Notice, you must have a new National Medical Support Notice rescinding the previous Notice or other applicable documents.

4. Deadline:

- Thirty-five (35) days from the date the order or guardianship documents are signed by a judge;
- Ineligible dependents will be dropped off the plan at the end of their ineligibility date even if the 35 day deadline is not met;
- Based on the National Medical support Order directing the employer to enroll an employee's child in the plan, the enrollment will be processed even if the 35 day deadline is not met.

NOTE: If the member does not consent, the member and dependent will be enrolled in the lowest cost Parent Plus Plan.

Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare (Part A, Part B or Part D) or Medicaid (gaining KCHIP is not a valid Qualifying Event)

Health Insurance Coverage	▪ Drop coverage for themselves, their spouse and/or their dependents if they become eligible and enrolled in Medicare or Medicaid; ▪ Medicare eligible over 65 who are actively employed by a KEHP participating agency have a choice to retain KEHP coverage or to take their benefit under Medicare. ▪ Members diagnosed with End Stage Renal Disease before becoming eligible for Medicare are eligible for KEHP coverage for the first 30 months of their Medicare eligibility. • Employee may change plan options when dropping spouse or dependent
Healthcare FSA	• Employee may decrease election
Dependent Care FSA	• No change allowed
Waiver HRA	• No change allowed

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - Entitlement to Medicare
     - Copy of Medicare card; OR
     - Initial eligibility letter from Medicare Office
   - Entitlement to Medicaid
     - Initial eligibility letter from the Medicaid office; OR
     - Medicaid Eligibility/Termination Form signed by Debbie Keith from Division of Medicaid Services

2. **Forms to use:**
   - If employee dropping KEHP coverage – KEHP Enrollment Application showing a Waiver with NO HRA.
   - If dropping dependents – Dependent Drop Form
   - If requesting plan changes – Enrollment Application
   - If changing Healthcare - FSA Qualifying Event Change Form

3. **Effective Date:**
   - The first day of the month after the signature date

4. **Deadline:**
   - Thirty-five (35) days from the date the employee, spouse or dependent becomes entitled to and enrolls in Medicare or Medicaid;

- The Dependent Drop Form may be signed by the employee prior to the event date; however, the requested change will not be effective prior to the Qualifying Event date.

    - Gaining KCHIP is not a valid qualifying event. No changes are allowed.
    - Gaining KCHIP (SCHIP) or MEDICAID **PREMIUM ASSISTANCE** is a qualifying event for adding coverage.

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Benefit option has significant increase or decrease in cost

Health Insurance Coverage	• No change allowed
Healthcare FSA	• No change allowed
Dependent Care FSA	• Employee may make a corresponding change (increase or decrease). Increasing the election for a day care provider raising rates mid-year is only permitted if the provider is not a relative of the employee
Waiver HRA	• No change allowed

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - None

2. **Forms to use:**
   - FSA Qualifying Event Change Form

3. **Effective Date:**
   - The last day of the month in which the employee signs the appropriate paperwork.

5. **Deadline:**
   - Thirty-five (35) days from the Qualifying Event Date

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

Spouse has a different Open Enrollment period (includes military insurance coverage, except for Veteran's Administration benefits)

Health Insurance Coverage	• Add themselves, their spouse and/or dependents if spouse elected to drop coverage for them during his/her open enrollment period; • Drop themselves, their spouse and/or dependents if spouse elected to enroll them during his/her open enrollment period.
Healthcare FSA	• *After KEHP Open Enrollment and before January 1:* Employee may make corresponding change • *After 12/31* – No change allowed
Dependent Care FSA	• After KEHP Open Enrollment and before January 1: Employee may make election change that corresponds with election change under the other employer plan • After 12/31 – No change allowed •
Waiver HRA	• *After KEHP Open Enrollment and before January 1:* Employee may make corresponding changes and redirection of the state contributions • *After 12/31:* Employee may make corresponding changes but redirection of the state contribution is **not** allowed.

Important Things to Know About Making An Election Change Request For This Event

1. **What documentation is required:**
   - Letter from employer, on employer's letterhead, identifying Open Enrollment deadline, effective date, and persons who are being added to or dropped from the policy.

2. **Forms to use:**
   - If enrolling – Enrollment Application
   - If adding dependents – Dependent Add Form
   - If dropping dependents – Dependent Drop Form
   - If requesting plan changes – Enrollment Application
   - If changing FSA elections - FSA Qualifying Event Change Form

3. **Effective Date:**
   - The effective date to add or drop will be the same as the effective date of the spouse's Open Enrollment effective dates.

4. **Deadline:**
   - Thirty-five (35) days from the Qualifying Event Date
   - The event date is the last day of the spouse's Open Enrollment period

- The application, Dependent Add Form or Dependent Drop Form may be signed by the employee prior to the event date

Reminder: If employees miss the deadline to submit their change request, the next chance will be at Open Enrollment or with another consistent Qualifying Event, whichever comes first.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

I Continuation of Benefits

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more employees. The law requires that employers offer employees and/or their *dependents* continuation of medical coverage at group rates in certain instances where there is a loss of group insurance coverage.

II Eligibility

A qualified beneficiary under COBRA law means an employee, employee's spouse or dependent child covered by the Plan on the day before a Qualifying Event. A qualified beneficiary under COBRA law also includes a child born to the employee during the coverage period or a child placed for adoption with the employee during the coverage period.

- **EMPLOYEE:** An employee covered by the KEHP has the right to elect COBRA continuation coverage if coverage is lost due to one of the following Qualifying Events:
  - Termination (for reasons other than gross misconduct) of the employee's employment or reduction in the hours of employee's employment; or
  - Termination of retiree coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

- **SPOUSE:** A spouse covered by the KEHP has the right to elect continuation coverage if the group coverage is lost due to one of the following Qualifying Events:
  - The death of the employee;
  - Termination of the employee's employment (for reasons other than gross misconduct) or reduction of the employee's hours of employment with the employer;
  - Divorce or legal separation from the employee;
  - The employee becomes entitled to Medicare benefits; or
  - Termination of a retiree spouse's coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

- **DEPENDENT CHILD:** A dependent child covered by the KEHP has the right to continuation coverage if group coverage is lost due to one of the following Qualifying Events:

    - The death of the employee-parent;
    - The termination of the employee-parent's employment (for reasons other than gross misconduct) or reduction in the employee-parent's hours of employment with the employer;
    - The employee-parent's divorce or legal separation;
    - Ceasing to be a "dependent child" under the Plan;
    - The employee-parent becomes entitled to Medicare benefits; or
    - Termination of the retiree-parent's coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

III Loss of Coverage

Coverage is lost in connection with the foregoing Qualifying Events, when a covered employee, spouse or dependent child ceases to be covered under the KEHP terms and conditions as in effect immediately before the Qualifying Event (such as an increase in the premium or contribution that must be paid for employee, spouse or dependent child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an employer eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

IV Maximum Coverage Period

Coverage may continue up to:

- 18 months for an employee and/or dependent whose group coverage ended due to termination of the employee's employment or reduction in hours of employment;
- 36 months for a spouse whose coverage ended due to the death of the employee or retiree, divorce, or the employee becoming entitled to Medicare at the time of the initial qualifying event;
- 36 months for a dependent child whose coverage ended due to the divorce of the employee parent, the employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the employee, or the child ceasing to be a dependent under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the employer filed Chapter 11 bankruptcy.

V Disability

An 11 month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial 18 month continuation period to be entitled to the additional 11 months of coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

VI Second Qualifying Event

An 18-month extension of coverage will be available to *spouses* and *dependent* children who elect continuation coverage if a second *qualifying event* occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second *qualifying event* occurs is 36 months. Such second *qualifying event* may include the death of a covered *employee*, divorce or separation from the covered *employee*, the covered *employee's* becoming entitled to *Medicare* benefits (under Part A, Part B, or both), or a *dependent* child's ceasing to be eligible for coverage as a *dependent* under the Plan. These events can be a second *qualifying event* only if they would have caused the qualified *beneficiary* to lose coverage under the Plan if the first *qualifying event* had not occurred. *You* must notify the Plan within 60 days after the second *qualifying event* occurs if *you* want to extend *your* continuation coverage.

VII Who Administers COBRA for the Kentucky Employees' Health Plan (KEHP)?

Humana, the KEHP's Third Party Administrator (TPA), has partnered with Ceridian COBRA Continuation Services to administer COBRA for KEHP members. Ceridian uses an on-line enrollment system called WebQE as the method for COBRA notification. As the Insurance Coordinator, you must enter your employee's new hire and COBRA Qualifying Event information via the Internet based WebQE system. Ceridian will be responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.

VIII How are Qualified Beneficiaries Notified of their Rights?

COBRA regulations provide that a group health plan is required to provide written notice of COBRA rights to all covered employees and their spouses, if any, when coverage under the plan first commences. The regulations require that group health plans furnish written notice of COBRA rights no later than 90 days after their coverage begins. This written notice may be referred to as either the Initial Notice or the General Notice.

This Initial Notice or General Notice will be mailed to employees by Ceridian COBRA Continuation Services immediately after the Insurance Coordinator enters the employees' new hire information or COBRA Qualifying Event information on Ceridian's WebQE.

IX When a Qualifying Event Occurs: Who Must Notify Whom?

The employer cannot detect the occurrence of some Qualifying Events, because information concerning such events is uniquely within the control of the qualified beneficiary. If the event results in a loss of coverage under the group plan then the COBRA regulations require that the covered employee or other qualified beneficiary notify the Insurance Coordinator of the following events:

- Divorce or legal separation;
- Dependent children ceasing to qualify as dependents under the terms of the plan;
- The occurrence of a second Qualifying Event after the qualified beneficiary becomes entitled to COBRA continuation coverage with the maximum duration of 18 or 29 months; and
- A determination by the Social Security Administration (SSA) that a covered employee or other qualified beneficiary is disabled, or a subsequent determination by the SSA that the individual is no longer disabled.

The employees or their qualified beneficiaries are required to notify you no later than 60 days after the Qualifying Event. Failure to notify you in a timely manner will result in unavailability of COBRA continuation coverage for the affected individuals.

The employer must notify the employees of some Qualifying Events. If the event results in a loss of coverage under the group health plan, the employer must notify the covered employees and their spouses and dependent children of their COBRA rights for the following events:

- Death of the covered employee;
- Termination of employment (other than for gross misconduct);
- Reduction in the employee's hours of employment;
- The employee's entitlement to Medicare (under Parts A or B, or both);
- The employer's bankruptcy; and
- Break in coverage due to a transfer between agencies within the KEHP.

When employees experience any of the above Qualifying Events, you must enter all necessary information in Ceridian's WebQE. Ceridian will then mail all necessary notifications and forms within the required timeframes.

X How Much Will COBRA Continuation Coverage Cost?

COBRA regulations do not require employers to pay for continuation coverage. Instead, employers are expressly permitted to charge employees 100 percent of the cost of the group health coverage, plus an additional 2 percent, for a total premium of 102 percent. The COBRA rates are included in this manual (refer to Appendix G) and the KEHP Web site. The additional two percent covers the added cost for administering COBRA continuation coverage.

- American Recovery and Reinvestment Tax Act of 2009 - The Act includes a subsidy for certain qualified beneficiaries who are entitled to COBRA coverage in connection with an involuntary termination that occurred, or will occur between September 1, 2008 and (as extended under the Temporary Extension Act) March 31, 2010. (Currently Congress is considering and extension through December 31, 2010). Ceridian administers our COBRA and ARRA.

NEW EMPLOYEE ORIENTATION

For a printable version of all forms, please go to the Personnel Cabinet's Web site at:

http://personnel.ky.gov/dei/09planyear/inscoord.htm

I New Employee Orientation

This Chapter has been designed to assist Insurance Coordinators with the enrollment of new employees. All new employees should receive the following information:

- Memorandum regarding Notice about Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act (this notice is required by Federal guidelines and can be found in Appendix B; and
- Health insurance checklist (Appendix C). New employees should be given this checklist for review and they should check each item as explained to them by the Insurance Coordinator. This checklist ensures that employees have received the required information and protects the Insurance Coordinator in the event of a discrepancy.

II KEHP Insurance Checklist

A health insurance checklist is included in Appendix C to ensure consistency in the explanation of Health Insurance and Flexible Spending Account benefits.

- The checklist has been designed to cover essential health insurance information that MUST be given to new employees during the initial benefit orientation session.
- The completed checklist, along with a record of the employees' elections should be made a part of the employees' personnel files as an acknowledgement of receipt of information. Copies of all forms should be given to the employees once they have been completed.
- If your agency is already using a benefit orientation form, make sure you incorporate all topics included on this checklist.
- On the last page of the health insurance checklist, new employees must respond to the question regarding previous employment within the last 11 days with another agency participating in the Kentucky Employees' Health Plan (KEHP).
    - If the employees' break in service is 11 days or greater, the employees may make new elections, including changes to the smoking status.

- If the employees' break in service is less than 11 days, the employees may not change their previous elections unless they experience a Qualifying Event that would allow a permitted mid-year election change.

III Memorandum Regarding Notice About Special Enrollment Rights and Notice About Women's Health and Cancer Rights Act

Federal law requires that all employees receive notification of the Notice of Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act. A copy of this notice is provided for your assistance (refer to Appendix B).

LEAVES OF ABSENCE for Health Insurance ONLY

(See the Flexible Benefits Section for information on FSAs and HRAs.)

I Leave Without Pay (LWOP)

These guidelines apply to eligibility for KEHP and are not meant to replace any LWOP guideline established by an agency.

New Employees going on LWOP before Health Benefits Begin

In some instances a new employee may go on LWOP before the effective date of health insurance coverage, in this case the following rules will apply if the Enrollment Application has been completed and signed within the required 30 day period after the hire date.

Health Insurance coverage will be effective on the "**later of**" the following two dates:

- The 1st day of the second month following the date of hire or
- The 1st day of the pay period following the pay period in which they return from LWOP.

However, if the pay an employee receives is not sufficient to cover his/her portion of the premium, the employee must submit a personal check for the amount due.

Starting LWOP

- **KRS Chapter 18A Agencies and Technical Schools(780 KAR 6.602 and 780 KAR):**

Employees on approved leave without pay (Except education LWOP) must work **at least one day in the previous semi-monthly period** (the first through the 15th or the 16th through the end of the month) to be eligible for the Commonwealth employer contribution for health insurance for the next period. An employee can be on intermittent LWOP and continue to be eligible for the employer contribution for health insurance as long as the employee works at least one day during each previous semi-monthly period.

- **Non KRS Chapter 18A Agencies:**

Employees on approved leave without pay must work **at least one day during the semi-monthly period** (the first through the 15th or the 16th through the end of the month) to be eligible for the Commonwealth employer contribution for health insurance for that period. An employee can be on intermittent LWOP and continue to be eligible for the employer contribution for health insurance as long as the employee works at least one day during each semi-monthly period.
However, if the pay an employee receives is not sufficient to cover his/her portion of the premium, the employee must submit a personal check for the amount due.

Until KHRIS implementation, any portion of a premium due by the employee must be submitted to the Insurance Coordinator by the 20th day of the coverage month (i.e. May premium is due by May 20th. The employee's personal check must be payable to the Kentucky State Treasurer. The Insurance Coordinator will forward the payment to the Financial Management Branch (FMB). After KHRIS implementation, this payment process will change.

NOTE: If an employee has any leave time, this leave time MUST be used consecutively (i.e. if an employee has 10 days of annual or sick leave, they cannot use one day per pay period to qualify for the employer contribution for health insurance. They must use the 10 days consecutively.

Extended LWOP

If an employee is on approved leave without pay and does not work at least:

- **KRS 18A Agencies and KAR 780 Agencies:** one day during a semi-monthly period (the first through the 15th or the 16th through the end of the month) the employee will not be eligible for the employer contribution for health insurance for the next period.

- **Non-KRS 18A Agencies:** one day during each semi-monthly periods (the first through the 15th or the 16th through the end of the month) the employee will not be eligible for the employer contribution for health insurance for that period.

The Insurance Coordinator must submit a Health Insurance Update Form to DEI providing the employee's approved LWOP begin date and the health insurance termination date (end of the semi-monthly period).

Examples: These examples apply to KRS18A Agencies and KAR 780 Agencies:

- Employee on approved LWOP or suspension and works 1 day during the period of the 1st through the 15th.
    - Health Insurance ends the last day of the month.
- Employee works at least one day between the 16th and the end of the month.
    - Health Insurance ends on the 15th of the following month.
- If the pay an employee receives is not sufficient to cover his/her portion of the premium, the employee must submit a personal check for the amount due

Examples: These examples apply to Non-18A Agencies or KAR 780 Agencies:

- Employee on approved LWOP or suspension and works 1 day during the period of the 1st through the 15th.
    - Health Insurance ends on the 15th of the current month.

- Employee works at least one day between the 16th and the end of the month.
    - Health Insurance ends on the last day of the current month
- If the pay an employee receives is not sufficient to cover his/her portion of the premium, the employee must submit a personal check for the amount due

Note: When there is a loss of coverage the Insurance Coordinator must submit an Update Form to the Department of Employee Insurance indicating the employee is on LWOP or suspended. The IC must also enter the event in Ceridian's WebQE system to ensure the employee is notified of their rights under COBRA. The IC must also submit an Update Form to **reinstate** the employee's health insurance when the employee regains eligibility.

Note: The Commonwealth of Kentucky's regulations which address LWOP for employees of executive branch agencies are set forth in 101 KAR 2:102, Section 2 (2)(c) (Classified leave administrative regulations); and 101 KAR 3:015, Section 2 (2)(c) (Leave administrative regulations for the unclassified service). According to the amended regulations (July 15, 2009):

> An eligible employee for state contributions for health benefits under the provisions of KRS Chapter 18A shall have worked or been on paid leave, other than education leave, during any part of the previous pay period.

Note: If an employee fails to submit appropriate premium payments due within the specified deadline, the ENTIRE POLICY will be canceled. If this occurs, the Insurance Coordinator should request a refund of any employer contribution amount paid.

Note: When an employee is granted approved extended LWOP, the Insurance Coordinator must send the Guidelines for Benefits While on Approved LWOP memo.

Note: Worker's Compensation – being on Worker's Compensation or being hurt on the job has no effect on LWOP or an employee's health insurance coverage. However, if an employee goes on extended LWOP the employee loses eligibility for health insurance coverage.

Note: As an employer, agencies who participate in the KEHP may have different guidelines for administering LWOP programs; this guidance is established for Health Insurance and FSA coverage only.

B. LWOP and cross-reference

If an employee is on LWOP and loses coverage the cross-reference payment option must be broken. DEI will notify the remaining spouse's Insurance Coordinator that one of the cross-reference employees is on LWOP and the remaining employee will be permitted to move from "family" coverage to either "parent plus" or "single" coverage.

If the remaining plan holder wishes to elect dependent coverage for the employee on LWOP they MUST complete an Enrollment Application to change their dependent coverage (change from Parent Plus/Single to Family plan) within 35 days of that loss of planholder status. The remaining plan holder would then be responsible for the total employee contribution for the plan.

If LWOP results in a loss of coverage, the IC must enter the event in Ceridian's WebQE system to ensure the employee is notified of their rights under COBRA.

C. During LWOP

While employees are on LWOP, the following could occur:

- **There is an Open Enrollment Period**
  - Employees that are on LWOP during the Open Enrollment period will not receive an Open Enrollment packet.
  - Employees that elected COBRA will receive Open Enrollment packets from the COBRA administrator.
  - Upon returning to work, the employees are entitled to receive the Open Enrollment information from the Insurance Coordinator. Employees will have 35 days from the date they return to work to make their Open Enrollment elections.

- **The Employees Experiences a Qualifying Event**
  - Employees on LWOP who experience a Qualifying Event must follow the same Qualifying Event rules as other employees. However, they must request the mid-year election change within 35 days from the return to work date.
  - The same rules as defined in the Returning from LWOP section below will be applied to determine the effective date of coverage.

D. Returning from LWOP

- Eligibility for the employer contribution

KRS Chapter 18A Agencies and Technical Schools (780 KAR 6.602 and 780 KAR):
Employees who return from approved LWOP or suspension must work at least one day in the PREVIOUS semi-monthly period to be eligible to receive the employer contribution for the current period.

Example:
Employee returns from approved extended LWOP or suspension.
- Employee works at least one day between the 1st and the 15th of the month.
  - Health Insurance starts on the 16th of the current month.
- Employee works at least one day between the 16th and the last day of the current month.
  - Health Insurance starts on the 1st of the next month.

Non-18A Agencies or KAR 780 Agencies:
Employees who return from approved LWOP or suspension must work at least one day in the CURRENT semi-monthly period to be eligible to receive the employer contribution for the current period.
- Employee works at least one day between the 1st and the 15th of the current month.
  - Health Insurance starts on the 1st of the current month, gain eligibility for the period in which they return to work.
- Employee works at least one day between the 16th and the end of the current month.
  - Health Insurance starts on the 16th of the current month, gain eligibility for the period in which they return to work.

Eligibility for coverage changes

Any employee who returns to work after being on approved LWOP will automatically be reinstated to the elections he/she had prior to LWOP status, unless the previous plan is no longer offered.

An employee who returns to work after being on approved LWOP will not be eligible to make any changes to his/her insurance coverage unless:

- the employee experienced a Qualifying Event and applies for an appropriate change no later than 35 days from his/her return to work date
- the employee returns in a new Plan Year and the employee was on approved LWOP during the Open Enrollment period. The employee must apply for a coverage change no later than 35 days after the return

The Insurance Coordinator must provide the necessary applications upon return.

II Family Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of job-protected leave for certain family and medical reasons. Employees are eligible for FMLA leave if they have completed 12 months of service and worked or been on paid leave at least 1,250 hours in the 12 months proceeding the first day of FMLA leave. This leave is available annually.

The employees may choose to:

- use paid (annual, sick or compensatory) leave concurrently with FMLA leave (101 KAR 2:102);
- use unpaid leave during the FMLA leave; or
- reserve 10 days of accumulated sick leave prior to being placed on FMLA leave.

NOTE: When employees are granted FMLA leave, the Insurance Coordinator should send the Guidelines for Benefits While on Approved Family Leave memo (Appendix E). While employees are on unpaid FMLA or on Military leave, they may choose to keep their Flexible Spending Accounts active. Refer to the Qualifying Event Chart in Chapter 3 for the specific payment options.

Employees on unpaid FMLA and enrolled in a Healthcare FSA may elect COBRA.

Employees on unpaid FMLA and enrolled in a Dependent Care FSA are NOT eligible for COBRA benefits for the Dependent Care FSA. However, if IRS regulations are met, the employee on unpaid FMLA may continue to file dependent care claims for the remaining funds in their account until the end of the plan year.

NOTE: Being on Worker's Compensation or being hurt on the job has no effect on FMLA or your health insurance.

A. Starting FMLA leave

- FMLA leave is not a Qualifying Event to change health insurance elections.

- When employees begin FMLA leave, the employer contribution for health insurance must continue through the leave period.
- Employees are responsible for the employees' share of the health insurance premiums. Employees may choose to:
  - Cease contributions (terminate entire policy);
  - Prepay the coverage contributions for the FMLA leave period;
  - Choose the pay-as-you-go method. If employees choose this method of payment:
    - The employees' contributions are due at the same time contributions would be due if made by payroll deduction;

  - The Insurance Coordinators collect the premium check (payable to the Kentucky State Treasurer) and forward it to:

    Financial Management Branch
    Department of Employee Insurance
    Personnel Cabinet
    501 High Street, 2nd Floor
    Frankfort, Kentucky 40601

    Please note that employees who begin **unpaid** FMLA should not be receiving a paycheck from your agency.

B. During FMLA

While employees are on FMLA, the following could occur:

- There is an Open Enrollment Period

  Employees who are on FMLA during Open Enrollment and are still covered through the KEHP will receive an Open Enrollment packet from their Insurance Coordinator.

  Employees who choose to cease contributions, which stop coverage, are not eligible for health insurance under the Kentucky Employees Health Plan (KEHP) until they return to work. If the employee returns to work, they will have 35 days to make Open Enrollment elections.

- Employees experience a Qualifying Event

  Employees on FMLA that experience a Qualifying Event will have 35 days from their return to work date to request a status change.

C. Returning from FMLA leave

- Employees returning from FMLA leave, where coverage was stopped during the leave must be reinstated to the prior elections unless there has been an intervening status change, in which case, the employees will have 35 days from their return to work date to request a status change.

- If the employees chose to suspend health insurance coverage during the FMLA leave, the employees may be reinstated to the prior elections on the day they return to active status.
- If the employee is reinstated between the 1st and the 15th of a month, the employees will be responsible for payment of premiums for the entire month at the new coverage level, if applicable.
- If the employee is reinstated between the 16th and the end of a month, the employees will be responsible for payment of premiums for the one half month of reinstatement at the new coverage level, if applicable.
- If the employee had coverage cancelled due to non-payment of premiums, the employees are to be reinstated to the prior elections upon payment of all past-due premiums.
- If the employee chose suspension of coverage or fails to pay past-due premiums, the agency is to request a refund of the employer contribution for the applicable months.

D. Not returning from FMLA leave

When employees have exhausted FMLA leave, but do not return to work (begin LWOP), the Insurance Coordinator must notify the employees of their COBRA rights (if eligible), regardless of their insurance status during the FMLA leave.

For purposes of COBRA, the date of this COBRA Qualifying Event is the date the FMLA leave ends. Employees are eligible for 18 months of COBRA coverage.

III Paid Leave

Employees who have worked or been on paid leave (annual, sick or compensatory time) for at least 1 day during a semi-monthly period will be eligible for the state contribution for that half of the month. Paid leave must be used consecutively.

IV Military Leave

Employees called to active military duty are eligible for health benefits through the United States government. The employees' dependents may also be eligible for military health insurance.

A. Starting military leave

- Employees may stop their health insurance coverage on the last day of the semi-monthly period in which they are activated with the armed services. This option will allow employees to start their health insurance coverage immediately upon return to active employment. This stop-and-start process will in no way negatively impact employees with regard to pre-existing conditions.

- Employees may elect to maintain their current level of health insurance coverage, as well as maintain military health care coverage. They must ensure that the applicable premiums are available via payroll deduction or

are received by their Insurance Coordinator no later than the 20th day of the month of the coverage month.

NOTE: The premium referred to above would include the total monthly premium (employee and employer cost) if the employee does not have paid leave status.

NOTE: Refer to the Qualifying Event section in Chapter 3 regarding Flexible Spending Accounts during military leave.

Employees called to active duty must elect one of the preceding options for their health insurance during the time they are activated. The only option that may be affected by the minimum or maximum length of activation is dependent coverage and the employees are responsible for that verification. All premiums due upon return from active duty will be determined by the date of return to active employment.

B. During military leave

If employees elect to maintain their health insurance while on leave, they must ensure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 20th day of the month of the coverage month.

NOTE: The premium referred to above would include the total monthly premium (employee and employer cost) if the employee does not have paid leave status.

NOTE: Refer to Qualifying Event section in Chapter 3 for information regarding Flexible Spending Accounts while on military leave.

C. Returning from military leave

Employees returning from military leave will have all benefits (health insurance and Flexible Spending Accounts) reinstated the date they return, (first day of the second month rule does not apply) without any waiting period for pre-existing conditions.

NOTE: Employees returning from military leave have the option to delay the reinstatement of their prior elections until military coverage ends. During that time, employees may waive coverage and enroll in a stand-alone HRA until Tri-care ends. Employees electing this option MUST present supporting documentation of the military coverage end date and coverage will be reinstated the first day of the month following the date of the loss of coverage through Tri-care.

Employees returning between the 1st and the 15th of the month will need to pay the employee portion (family, couple, parent plus or single, if applicable) of the insurance premium for the month of return. Employees returning on the 16th of the month or later will be responsible for one-half month premium.

PREMIUM BILLING AND RECONCILIATION

I Overview

The Premium Billing and Reconciliation (PB&R) system is used to facilitate the reconciliation and management of health insurance enrollment data and premiums. By managing all premiums, the PB&R system supports the Commonwealth's self-funded insurance model.

In order to manage the overall functioning of the system, the Personnel Cabinet, through DEI, established the **Financial Management Branch (FMB). The FMB is responsible for overseeing the following areas:**

- Creation of health insurance bills and administration fee bills using Web-billing;
- Reconciliation of health insurance coverage with all agencies and administrators;
- Posting of all premium payments and adjustments; and
- Reporting and resolution of discrepancies.

The Flexible Benefits Branch (FBB) is responsible for overseeing the following areas:

- Creation of FSA /HRA bills using Web-billing;
- Reconciliation of FSA and HRA elections with all agencies and administrators;
- Posting of all premium payments and adjustments; and
- Reporting and resolution of discrepancies.

II Health Insurance Billing Statements

A. State government agencies

State government agencies do not receive a bill statement. The FMB receives a file extract from the state payroll system (UPPS). Health insurance, FSA and HRA premiums and administration fees are posted into the PB&R system automatically from this file.

Once the file extract has been loaded into the PB&R system, the FMB and FBB reviews the results and notifies each state agency's Insurance Coordinator about any premium discrepancies.

B. Boards of education

- Employee portion of the health insurance and FSA premiums
  Boards of education have a monthly bill statement (semi-monthly for FSA/HRA) generated by PB&R's Web Billing database **(the web address is:** http://personnel.ky.gov/**)** for the employee portion of the health insurance, FSA and HRA premiums only.

  Insurance Coordinators are responsible for reconciling the monthly web billing statements (or semi-monthly for FSA/HRA) to deductions made from the board of education payroll system and make any necessary changes to the web bill:

  For example, the *Remove* function in Web Billing indicates that a person on the bill was removed. An example of removing a record would occur if the employee terminates employment or transfers and the person still shows on the bill or if the employee did not make a payment for the month. Note that if you remove a record from a bill but the appropriate action has not been taken to change the record in the Group Health Insurance system (GHI), the record will appear again on the next month's web billing statement. If the termination is due to termination of employment, the IC should log into the web enrollment system and click on *IC Functions* to complete termination of health coverage or FSA/HRA within 60 days. If the termination is past 60 days, the IC will need to complete an Update Form and fax it to the Enrollment Information Branch at (502)564-1085, or if for an FSA/HRA the IC will need to complete a Flexible Spending Account Qualifying Event Change Form and fax it to the Flexible Benefits Branch at 502-564-0364.

  For other terms that don't meet these criteria, the IC will need to contact DEI.

NOTE: DEI processes terminations from the MUNIS Remittance file that the ICs submit monthly to the Kentucky Department of Education (KDE). It is the Department of Education's responsibility to reconcile the unadjusted monthly web-billing statement to the Munis file to determine whether the Insurance Coordinators are processing terms, qualifying events, and other enrollment actions in a timely manner. The Enrollment Information Branch (EIB) must be notified of all terminations in a timely manner. For any questions concerning your monthly web billing statement, please contact FMB at (502)564-9097.

It is important to note that the premiums received MUST match the monthly or semi-monthly web billing statement.

- Employer portion of the health insurance or HRA premiums

  KDE pays the employer portion of the health insurance or HRA premiums and the administration fees. ICs or Payroll Officers with questions related to

MUNIS need to contact the Kentucky Department of Education (KDE) at (502)564-3846.

C. Health departments and quasi governmental agencies

Currently, Health Departments do not participate in the KEHP Flexible Spending Account Program and only a limited number of Governmental Quasi' agencies participate.

The PB&R's Web Billing system generates monthly (semi-monthly for FSA/HRA) bill statements for health departments and quasi governmental agencies (http://personnel.ky.gov/).

Insurance Coordinators are responsible for reviewing the monthly (semi-monthly for FSA/HRA) web billing statements for accuracy and making any necessary changes.

For example, the *Remove* function in Web Billing indicates that a person on the bill was removed. An example of removing a record would occur if the employee terminates employment or transfers and the person still shows on the bill or if the employee did not make a payment for the month. Note that if you remove a record from a bill but the appropriate action has not been taken to change the employee's record in the Group Health Insurance system (GHI), the record will appear again on the next month's web billing statement. If the termination is due to termination of employment, the IC should log into web enrollment and click on *IC Functions* to complete termination of health coverage, FSA or HRA within 60 days. If the termination is past 60 days, the IC will need to complete an Update Form and fax it to the Enrollment Information Branch at (502)564-1085. If the termination is for an FSA or HRA, the IC will need to complete the Flexible Spending Account Qualifying Event Change Form, and fax it to the Flexible Benefits Branch (FBB) at 502-564-0364.

For other terminations that do not meet this criterion, the IC will need to contact DEI.

III Detailed Description of the Billing Statements

A user guide to assist with processing web bills for health insurance and FSA is located on DEI's Web site.

- http://kehp.ky.gov
- On the right hand side of the screen, click on *Your KEHP Online Access* on the top right of the screen.

NOTE: If your agency's HRA and FSA programs are administered by the Department of Employee Insurance (DEI), you are responsible for completing the HRA and FSA web bill on-line. This bill is a separate statement from the health insurance web bill.

NOTE: Each health department's web bill displays administration fees that are not included in the total owed on the bill. Each health department is responsible for reviewing the administration fees for accuracy. For example, an employee that should be terminated but is still listed on the web billing statement. A separate web bill for all health departments' administration fees is generated for the central office of the health department.

For questions concerning your monthly web billing statement, please contact FMB at (502)564-9097.

IV Premium Refunds

A. When to request a refund

The following list, while not all-inclusive, defines when a refund may be requested:

- A check is issued in error;
- An employee terminates at the end of the month and one-half the premium for the following month is deducted and sent to DEI;
- An employee is enrolled with the wrong option or coverage level;
- The occurrence of a qualifying event Qualifying Event (see specific information under C below); or
- An employee is ineligible or becomes ineligible (see specific information under C below).

B. Time limits for refund requests for health insurance premiums

Refunds will be restricted to the beginning of the current plan year to a maximum period of 60 days, except in the event of the death of a covered person (see C below). Note that any mid-year election change resulting in the termination of a covered person will be effective on the date as designated under the terms of the KEHP. Therefore, if DEI receives notification of a termination more than 60 days after the event causing the termination, the premium will be refunded as shown in the following table:

Notification received in:	Count from:	Months for which premium is to be refunded:
January	January 31	January
February	February 28	January and February
March	March 31	February and March
April	April 30	March and April
May	May 31	April and May
June	June 30	May and June
July	July 31	June and July
August	August 31	July and August
September	September 30	August and September

October	October 31	September and October
November	November 30	October and November
December	December 31	November and December

NOTE: If a refund is due, you can either take it as a credit to your account or request it in writing from the FMB or FBB. You must **NOT DO BOTH**!

C. Time limit for refund requests for FSA/HRA Contributions

A refund of FSA/HRA contributions will only be given for up to 60 days from the end of the pay period in which the qualifying event occurred. The exception to this rule is the qualifying event of death, in which the HRA contributions are eligible to be refunded back to the first day of the plan year (if necessary).

Example:

- Qualifying Event is on May 5
- Update Form is received on October 7
- End of the semi-monthly pay period from the QE is May 15; therefore a refund will be given for the semi-monthly pay periods of May 16 – May 30; June 1 – June 15, June 16-June 30 and July 1- July 15.

Example:

- Qualifying Event of *death* is on May 5
- Update Form is received on October 7
- End of the semi-monthly pay period from the QE is May 15; therefore a refund will be given for the semi-monthly pay periods of May 16 – May 30; June 1 – June 15, June 16-June 30 and July 1- July 15, July 16-July 31, August 1-August15, August 16 – August 31, September 1 – September 15, September 16 – September 30, and October 1-October 15.

D. Refunds due to eligibility changes

Effective March 1, 2010.

- **Death of a covered employee.** The account of a deceased employee will be reimbursed funds, with no time limits, as follows:
    - If the employee was enrolled in a Single plan and the employee's date of death is between the 1st and the 15th of the month, the employee's account will be refunded any premiums paid for the month.
        - If the employee was enrolled in an HRA and the date of death is between the 1st and the 15th of the month, the agency will receive a refund for the paid contributions for the semi-monthly period between the 16th and the last day of the month.
        - If the employee was enrolled in an FSA and the date of death is

between the 1st and the 15th, the employee's account will receive a refund for the semi-monthly period between the 16th and the last day of the month.

- If the employee was enrolled in a Single plan and the employee's date of death is between the 16th and the end of the month, the employee's account will not be refunded any premiums paid for the month of death.
- If the employee was enrolled in a Parent Plus, Couple or Family plan and a death occurs for a member and/or dependent coverage will continue through the end of the month of the death. The account will not be refunded any premiums paid for the month of death.

- **Dependent child becomes ineligible**. Employees that experience the Qualifying Event of dependent child becomes ineligible will be entitled to a refund. However, the *time limits for refund requests* rules detailed in B above apply.

E. Miscellaneous

DEI will issue refund checks for any erroneous overpayments. Refund checks, except for those to quasi governmental agencies and school districts, will be made payable to:

- The Kentucky State Treasurer, if the overpayment is to the employer;
- The employee, if the overpayment is the employee's portion; or
- Separate checks for both the employee and the Kentucky State Treasurer, if there is an overpayment of both employee and employer payments.

Refund checks will be sent to the appropriate Insurance Coordinator or payroll officer no later than thirty (30) days from receipt of the request for refund.

Refund requests must be initiated by either the Insurance Coordinator or the Payroll Officer.

V Other Payment Information

A. When will I be able to work my web billing statement?

Your billing contacts should receive a system generated email letting them know that the web billing statement has been generated. If your billing contacts have not received an email by the 22nd of the month letting them know that the bill statement is available, please check the Web Billing system to see if the statement is available.

B. To whom do I make the check(s) payable?

If you pay by paper check, make checks payable to the Kentucky State Treasurer.

Please note:

- **We do not accept cash**

- Everyone is encouraged to use the Web Billing function called *Easy Pay*. This function allows the agencies to do an ACH at no cost to the agencies (see the Web Billing User Guide).
- One payment can be submitted for both health insurance premiums and administration fees. However, a separate check must be issued for FSA/HRA premiums.
- The administration fees for health departments and school boards are paid by a central location; therefore, they are not included in the bill statement total.

C. Where do I mail the payment(s)?

Payments must be mailed to:

Personnel Cabinet
Department of Employee Insurance
Financial Management Branch
501 High Street, 2nd Floor
Frankfort, Kentucky 40601

D. Who do I contact if I have questions?

Contact the Financial Management Branch staff at (502) 564-9097. Contact the Flexible Benefits Branch at 502-564-0350.

REPORTS AND ONLINE ENROLLMENT

Throughout the year, the Department of Employee Insurance (DEI) will generate reports to the Insurance Coordinators. These reports are developed within the Group Health Insurance (GHI) database and are provided to inform Insurance Coordinators on applications processed through this database system. A description of each report and detailed information regarding what you are to do with each report are provided below.

Note: When the new KHRIS system goes live, this chapter will be updated to reflect the new reporting capabilities of the system as well as the new web enrollment system.

I Notice to Active Employees Age 65 and Over – State Employees

Every month, the Personnel Cabinet's Payroll Branch generates a report of all active state employees who will turn age 65 in the next 3 months. DEI's Member Services Branch distributes this report to appropriate Insurance Coordinators. The Notice to Active Employees 65 and Over in Appendix A should be mailed to the employees on that list.

All other Active Employees Covered Under This Plan Age 65 and Over.

Insurance Coordinators for non-state agencies must send the Notice to Active Employees 65 and Over in Appendix A to the employee three months before their 65th birthday.

II Pended Records

This report is generated weekly and is mailed, faxed or emailed (if agency has Entrust) to each agency's health Insurance Coordinator. If employees' applications have been pended for any reason, you will receive a report listing their Social Security Number, name, middle initial, the date it was pended and a note written by the EIB processor providing details about the pend action. The report also contains a message indicating the length of time the record has been in pended status and the action that will be taken if the issue is not resolved within the deadline. Pended records must be resolved within 60 days of the original pend date. Records in pended status for a

period greater than 60 days will be rejected. This will be done by the EIB and documentation received after the deadline will not be accepted. If an application has been rejected, you will be notified in writing by the EIB.

The deadlines for Qualifying Events do not change because of a pend action. Most Qualifying Events must be signed within 35 days after the event date. If a Dependent Add Form or a Dependent Drop Form has been signed within the deadlines, but it has been pended for supporting documentation or other reason, employees will have up to 60 days from the original pend date to submit the proper documentation or information requested.

III Web Reporting

You must log on to the Web site *Your KEHP Online Access* at https://openenroll.ky.gov **at least once each week** to access your employees' records and to generate varied reports pertinent to your agency. The reports provided by the on-line system contain information regarding your employees' status in the GHI system (active, pended, terminated, unedited or waived). It will also give you the ability to print a complete listing of your agency's employees, including their plan selection, plan cost, and Flexible Spending Account information, if applicable.

IV Web Enrollment System - *Your KEHP Online Access*

Your KEHP On-line Access is available throughout the year to Insurance Coordinators and to employees to access and enter their healthcare and flexible benefits elections. Retirees do not have access to the web enrollment system. Instructions are located at www.kehp.ky.gov.

Insurance Coordinators must use the web enrollment system to perform administrative functions and other Insurance Coordinator functions including viewing and changing your employees' elections, adding new employees, changing addresses and terminating coverage.

A. Performing administrative functions

Your KEHP Online Access provides you with a variety of administrative functions that include reviewing and updating your own benefits and enrollment information, resetting your employees' accounts and obtaining your agency statistics and reports.

NOTE : The GHI emails formally sent by email have been moved to the Web. Refer to IC functions Option from the Administrative Option screen.

B. Viewing and changing your employees' elections

This function allows you to review your employees' elections and to make any appropriate changes to your employees' demographic and other information.

Keep in mind that any changes made to employees' records via the web enrollment system must be supported by paper documentation signed by the employees. **Do not send documentation for changes you have made to DEI, maintain a file for this information at your location.**

C. Adding new employees

IC's at each agency must enter new employee and enroll them in benefits.

- You should enter the employee information plus all enrollment information.
- Ensure that you have a paper application signed by the employee within the appropriate deadline as supporting documentation. DO NOT mail this documentation to the Enrollment Information Branch (EIB), maintain a file of this information at your location.
- You must enroll your employees within 30 days of their hire date.
- You can not enter cross-reference applications or transfers on-line, please mail these applications to EIB.

D. Terminating coverage

This function allows you to enter your employees' termination of employment only. Terminations due to transfers, retirement, death, beginning a leave of absence or employees enrolled in a cross-reference payment option, and corrections to previously reported termination dates must not be entered using the web enrollment system. Report those terminations to the Enrollment Information Branch using an Update Form.

E. Accessing *Your KEHP On-line Access*

- To access *Your KEHP Online Access go to https://openenroll.ky.gov and* enter your login credentials.
- To access enrollment directions for Insurance Coordinators and for employees, you may either click on the links found after the log in screens, or you may go to **www.kehp.ky.gov**

FLEXIBLE BENEFITS

The KEHP Flexible Spending Account (FSA) Program, which is provided through a Section 125 plan, allows participating employees to pay for eligible healthcare and dependent care expenses with pre-tax dollars.

The KEHP currently offers the following Flexible Benefits to all eligible employees:

- Healthcare FSA;
- Dependent Care FSA; and
- Health Reimbursement Account (HRA)

Eligible employees who wish to participate in any of the Flexible Benefit programs MUST complete an on-line or paper Enrollment Application **EVERY YEAR** during the annual Open Enrollment period. Enrollment is **NOT automatic** and enrollment elections **WILL NOT** carry-over to the next Plan Year.

Section 125 plans are federally regulated and changes are not permitted on these plans outside of the annual Open Enrollment period unless employees experience an appropriate Qualifying Event.

The Qualifying Event Section in Chapter 3 outlines all of the permitted changes to a Healthcare FSA, Dependent Care FSA, and Health Reimbursement Account (HRA).

I Eligibility Requirements

Active employees who are eligible for the state-sponsored health insurance coverage may enroll in the Healthcare Flexible Spending Account or the Dependent Care Flexible Spending Account during Open Enrollment, or as a result of an applicable Qualifying Event. Refer to the Qualifying Event section in Chapter 3 for applicable events that would allow enrollment into the Flexible Spending Account program.

Employees who are eligible for state-sponsored health insurance coverage but elect to waive such coverage will be eligible for the stand-alone Health Reimbursement Account (HRA) with an employer contribution up to a maximum of **$2,100 per Plan Year**. The employee may not contribute any money to this account.

Employees who are eligible for the state-sponsored health insurance coverage and who elect to enroll in the Commonwealth Maximum Choice Plan will be eligible for the HRA that is embedded in the health insurance plan. The HRA employer contribution amount for the Commonwealth Maximum Choice Plan will be:

- $1,000 Single
- $1,500 Parent Plus
- $1,500 Couple
- $2,000 Family

NOTE: Employees who currently have a Health Savings Account (HSA) with their spouse's employer may NOT be eligible to have an HRA with the KEHP due to IRS guidelines, which govern cafeteria plans.

Employees may enroll in the FSA program within 30 days of their employment date or 30 days of their eligibility for benefits date. The effective date will be the first day of the second month from the date of hire (i.e. employee hire date is February 25; employee's effective date would be April 1). Indicate the effective date on the Enrollment Application and adjust the number of semi-monthly pay periods accordingly by using the chart in Section IV below.

NOTE: Active employees who are covered spouses on **a hazardous duty retiree's plan will not be eligible to direct the state contribution into an HRA. For more information, refer to Chapter 2, Section III, Double Dipping.**

Retirees, who return to work, are eligible to participate in the FSA programs. Retirees, who return to work, are eligible to participate in the stand alone HRA if they waive coverage through their respective retirement system.

II. Redirection of the Employer Contribution

Redirection is the ability of an employee to stop employer funds from going into a stand-alone HRA in order to start receiving an employer contribution toward a health insurance plan as a result of experiencing a permitted Qualifying Event.

There are NO Qualifying Events that allow an employee to stop a health insurance plan in order to enroll in a waiver with a stand-alone HRA, except returning from Military Leave. (See Chapter 6, Section IV, C for more information).

III Timely Filing of Claims

All claims must be submitted by March 31st of the following Plan Year. Services will not be covered unless the employees are eligible for benefits on the date services are rendered. For example: Employees who have coverage from 1/1 - 5/31, may submit claims for reimbursement up to 3/31 of the next calendar year, provided the ***dates of service*** of such claims are between 1/1 - 5/31.

IV Billing Period and Payment Due Reference Chart

Effective Date	Bill Period	Payment Due
January 1	1/1-1/15	1/15
	1/16-1/31	1/30
February 1	2/1-2/15	2/15
	2/16 – 2/28	2/28
March 1	3/1-3/15	3/15
	3/16-3/31	3/30
April 1	4/1-4/15	4/15
	4/16/-4/30	4/30
May 1	5/1-5/15	5/15
	5/16-5/31	5/30
June 1	6/1-6/15	6/15
	6/16-6/30	6/30
July 1	7/1-7/15	7/15
	7/16-7/31	7/30
August 1	8/1-8/15	8/15
	8/16-8/31	8/30
September 1	9/1-9/15	9/15
	9/16-9/30	9/30
October 1	10/1-10/15	10/15
	10/16-10/31	10/30
November 1	11/1-11/15	11/15
	11/16-11/30	11/30
December 1	12/1-12/15	12/15
	12/16-12/31	12/31

Employees who previously worked for a KEHP participating agency and had less than an 11 day break in service, and return to employment, will have the same elections and semi-monthly deductions as held prior to their break in service, unless an event has occurred that would allow a change.

Employees, who previously worked for a KEHP participating agency and had a break in service of 11 days or greater, and return to employment, will be allowed to make new elections as a "new employee", subject to the first day of the second month waiting period.

Employees who enroll in a Flexible Spending Account (Healthcare or Dependent Care) and/or an HRA during Open Enrollment **and who terminate employment before coverage is effective on January 1st,** will not be offered COBRA coverage for the upcoming plan year. However, they will be offered COBRA coverage for the prior year in which employment terminated, if they were enrolled. If they return to work after the plan year begins with less than an 11 day break in service, they will have the same elections they chose during the Open Enrollment period. Employees with a break in

service of 11) days or greater will be eligible to enroll as new employees, with an effective date of the first day of the second month after the date of employment.

V Payroll Processing

Open Enrollment

Payroll deductions will be set up through a file with the UPPS and MUNIS payroll systems. State agency and Board of Education Insurance Coordinators should not set up deductions during the Open Enrollment period unless instructed by DEI.

DEI will send FSA and HRA Open Enrollment information electronically to the Third Party Administrator.

VI Contribution Amounts

A. Healthcare FSA

The maximum allowable yearly contribution is $5,000.
The minimum allowable yearly contribution is $120.

B. Dependent Care FSA

The maximum yearly contribution amount depends on the employee's tax filing status as listed below:

- married filing separately → $2,500
- single and head of household → $5,000
- married and filing jointly → $5,000

C. Health Reimbursement Account (HRA)

Employees, who waive their health insurance coverage, if eligible, receive $2,100 annually from their employer into a stand-alone HRA. The maximum annual contribution is $2,100. If an employee terminates coverage any time during the Plan Year and is rehired during the same Plan Year, he/she **will not be eligible** to receive another $2,100 (or $175 per month) for the remaining months. For example, an employee waives coverage January 1 and terminates coverage (and HRA) on May 31. The employee would have access to the $2,100 for any expenses incurred between January 1 and May 31. The employee is re-hired in August for an October 1 effective date. The employee **will NOT** receive additional funds of $175 for October, November and December. However, the agency must still pay the monthly contributions to DEI for these months. if the employee has funds remaining in his/her account at the time of termination (May 31), the funds will be available for the remaining months (October – December).

Employees who have the embedded HRA with the Commonwealth Maximum Choice Plan receive the amount as indicated in Section I of this Chapter and on the Benefits Grid in the KEHP Handbook.

VII Types of Leave and Flexible Spending Accounts

A. Leave without pay (LWOP)

Beginning LWOP

Employees on LWOP must work at least one day during each semi-monthly pay period to be eligible to receive the employer contribution.

For example if the employee waives coverage and has the waiver HRA, and the employee works one day from the 1st through the 15th, the employee will be eligible to receive ½ of the employer contribution ($87.50) for that pay period.

If the employee works one day from the 16th to the end of the month, the employee will receive ½ of the employer contribution ($87.50) for that period.

However, if the net pay an employee receives is not sufficient to cover the contribution amount, the employee must submit a personal check for the amount due. If no personal check is received, the employee's coverage terminates the last day worked.

Until KHRIS implementation, any portion of a contribution due by the employee must be submitted to the Insurance Coordinator by the 20th of the month. The employee's personal check must be payable to the Kentucky State Treasurer. The Insurance Coordinator will forward the payment to the Financial Management Branch (FMB). After KHRIS implementation, this payment process will change.

If an employee is on approved LWOP, the waiver HRA, Healthcare and Dependent Care FSA will terminate the last day worked. The Insurance Coordinator must submit a Flexible Spending Account Qualifying Event Change Form reflecting the approved LWOP begin date.

Employees who lose the waiver HRA or Healthcare FSA because they did not work at least one day during a semi-monthly period must be entered into Ceridian's WebQE system to receive COBRA information. Dependent Care FSA is not eligible for COBRA.

Returning from LWOP

- **Eligibility for the employer contribution**

  An employee who returns to work after being on approved LWOP will become effective either the 1st or the 16th of the month. Any employee

who returns to work after being on LWOP will be reinstated to the same elections he/she had prior to LWOP status, unless they have experienced a Qualifying Event that would allow a change.

Example:

- Employee returns from approved LWOP between the first (1st) and the 15th of the month, the Health and FSA are reinstated on the 16th day of the same month and DEI expects half-month payments
- Employee returns from approved LWOP between 16th and the last day of the month, the Health and FSA are reinstated on the first of the following month and DEI expects a full month payment for that month

B. Family Medical Leave Act (FMLA)

When employees are granted FMLA leave, the Insurance Coordinator should send the *Guidelines for Benefits while on Approved Family Leave* letter in Appendix E.

- **Starting FMLA**
  - FMLA leave is not a Qualifying Event to make any changes to the healthcare FSA.
  - When employees begin paid or unpaid FMLA, the employer contribution for the HRA will continue until FMLA expires.
  - The employees are responsible for their Healthcare Flexible Spending Account. The employees may choose to:
    - Cease contributions (terminate the entire contribution);
    - Prepay the total contribution for the FMLA leave period;
    - Choose the pay-as-you-go method. If the employees choose this method of payment
      - The employees' contribution is due at the same time the contribution would be made by payroll deduction.
    - When the employees are on FMLA, the Insurance Coordinator should collect the FSA check (payable to the Kentucky State Treasurer) and forward contribution checks to:

      Personnel Cabinet
      Department of Employee Insurance
      Financial Management Branch
      501 High Street, 2nd Floor
      Frankfort, Kentucky 40601

- **Returning from FMLA Leave**

  If elections continued during FMLA, the elections continue with no change when the employee returns from FMLA.

  The employees may choose one of the following for their FSA:
  - Proration: Employees may elect to continue the same monthly contribution as prior to the FMLA leave and the annual amount is reduced by the contributions missed;

- Pay in advance of their leave.

- **Not returning from FMLA Leave**

  When employees have exhausted their FMLA leave, and do not return to work (begin LWOP), the Insurance Coordinator must notify the employees of their COBRA rights, regardless of the employees' FSA status during the FMLA.

  For purposes of COBRA, the date of the COBRA Qualifying Event is the date the FMLA leave ends. Employees are eligible for COBRA through the end of the Plan Year.

C. Military leave

Employees may discontinue their contributions to the Flexible Spending Account Program when they are activated with the armed services. This option will allow the employees to be reinstated when returning to employment from military leave. The employees may elect to continue at the same monthly contribution prior to military leave and the annual amount is reduced by the contributions missed; or

Employees returning between the 1st and the 15th of the month will be effective on their date of return BUT will have to pay the entire employee's monthly contribution for FSA. The employer will be required to pay HRA contributions for the monthly period in which the employee returns.

Employees returning on or after the 16th of the month will be effective on their date of return BUT will only need to pay half of the election for FSA. The employer will be required to pay the employer's portion of the contribution for HRA for the semi-monthly period in which the employees return.

VII Forms to Use

- Employees will complete an Enrollment Application upon hire, or enroll on-line, if they are electing coverage, waiving and enrolling in a new stand-alone HRA.
- Employees will complete an FSA Qualifying Event/Change Form to:
  - increase or decrease their Healthcare of Dependent Care FSA election; or
  - to enroll in or terminate their election.

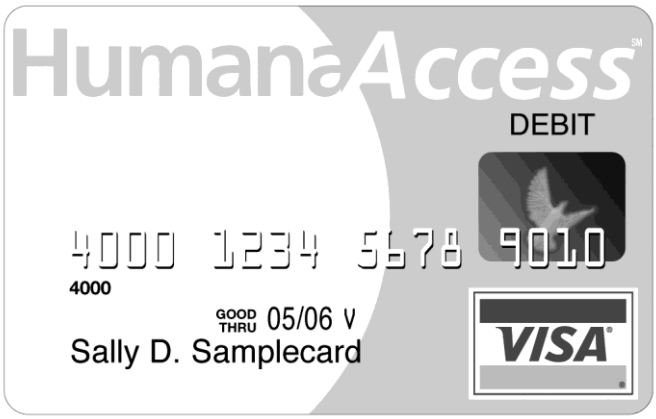
Forms are available on the web at www.kehp.ky.gov. Look under the Insurance Coordinator section.

VIII Humana*Access* VISA Cards (HAC)

A. Who will receive a HAC?

Employees who have elected an FSA, the Commonwealth Maximum Choice plan, or who have waived health insurance coverage and have an HRA will receive a Humana*Access* VISA Card (HAC) to pay for eligible covered expenses. Employees may use the HAC at the time they receive a covered service by simply swiping the HAC just like they are making a purchase. There is no PIN provided with the HAC; therefore, they must select "credit" at the time of purchase.

Employees must activate their HAC cards before they can be used to pay for covered eligible expenses.



B. Multi-year cards

Humana Access Visa Cards (HAC) are issued for multiple years, and are not reissued every Plan Year. If employees have funds in their account and they are making an eligible purchase, the HAC card will continue to work from year to year. The multi-year card will reduce the number of new cards the employees will receive.

C. Substantiation

- Traditional Paper Claims

  When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and mailing or faxing a Request for Reimbursement Form. Forms can be mailed to PO Box 14167, Lexington, KY 40512-4167 or faxed to 1-800-905-1851. You may obtain a Request for Reimbursement Form from the Third Party Administrator or print a copy from the KEHP website at http://kehp.ky.gov. You must include with your

Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

- The nature of the expense (e.g. what type of service or treatment was provided).
- The date the expense was incurred; and
- The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Medical Expense, you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the *Plan Year* in which they were incurred or during the Run Out Period.

- Electronic Payment Card (HAC)

  The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense.

  - In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including limitations as to card usage, the *Plan*'s right to withhold and offset for ineligible claims, etc.

    You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The Cardholder Agreement is part of the terms and conditions of your *Plan* and this *SPD*.

  - The card will be turned off when employment or coverage terminates. The card will be turned off if you fail to provide the correct documentation to Humana, when necessary to substantiate claims. If Humana does not receive substantiation (verification) from you within thirty (30) days after you swipe the Humana Access Card, then Humana will request this substantiation from you. If substantiation is not received within 30 more days (for a total of 60 days from the initial Humana Access Card swipe), then claims processing will be suspended. This suspension of claims will include the use of the Humana Access Card as well as reimbursements for traditional paper claims.

    The card will be turned off when you terminate employment or when coverage under the *Plan* ends. Contact your Third Party Administrator for reactivation of the electronic payment card if you elect COBRA, and after submission of your initial COBRA premium payment.

- You must certify proper use of the card. As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your HRA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your *spouse*, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

- HRA reimbursement under the card is limited to certain providers. Use of the card for HRA expenses is limited to merchants who are providers such as doctors and pharmacies.

- You swipe the card at the health care provider like you do any other credit card. When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit card. The provider is paid for the expense up to the maximum reimbursement amount available under the HRA (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the *Plan* that the expense for which payment under the HRA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

- You must obtain and retain a receipt/third party statement each time you swipe the card. You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:
  - The nature of the expense (e.g., what type of service or treatment was provided).
  - If the expense is for an over the counter drug, the written statement must indicate the name of the drug.
  - The date the expense was incurred.
  - The amount of the expense.

  You must retain this receipt for one year following the close of the *Plan year* in which the expense is incurred. Even though payment is made under the card arrangement, you may be required to submit a written third party statement (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator that a third party statement is needed. You must provide the third party statement to the Claims Administrator within 45 days (or such longer period provided in the letter from the Claims Administrator) of the request.

- There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your *Plan* is specified in the Cardholder Agreement.

NOTE: You should still obtain the third party receipt when you incur an expense and swipe the card, even if you think it will not be needed, in the event the receipt is requested by the Claims Administrator.

- Pay at the pharmacy with your Visa Humana*Access* Card.

  Here are the steps to take when paying at the pharmacy:

  - When you pick up your prescription, present your primary insurance card so your pharmacist can identify your copayment amount and bill your insurer.
  - Ask your pharmacist to follow the instructions on the Humana*Access* card to submit a second claim to Humana, which takes only a few minutes.
  - Then swipe your Humana*Access* card through the credit card machine, to make the payment.
  - Select "credit" – not "debit" – for your transaction.
  - Sign and save the receipt.

  To find a complete list of participating pharmacies, please visit kyhealthplan.com.

- You must pay back any improperly paid claims. If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the *Plan* for the unsubstantiated expense. The deadline for repaying the *Plan* is set forth in the Cardholder Agreement. If you do not repay the *Plan* within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense may be offset against future eligible claims under the HRA. The Plan further reserves the right to withhold the amount of any unsubstantiated expenses from your paycheck and to take any additional steps deemed necessary to properly account for any unsubstantiated expenses.

- You can use either the payment card or the traditional paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

- This plan reserves the right to initiate the following correction procedures to recoup money from participants for claims that are improperly paid from the health HRA (i.e., a claim that qualifies for after-the-fact-substantiation for which proper substantiation is not subsequently provided).
  - Deny Access to the Card. To ensure that no further violations occur, the card must be deactivated until the amount of the improper payment is recovered. In the meantime, the participant

must request reimbursements through other methods (e.g., by submitting traditional paper claims).

- Require Repayment. The employer may "demand" that the participant repay the improper payment. A letter to the participant will be sent identifying the amount, the reasons for requiring repayment, and the timeframe in which the repayment must be made.
- Withhold From Pay. If the demand for repayment is unsuccessful, then an amount equal to the improper payment must be withheld from the participant's pay or other compensation, to the full extent permitted under applicable law.
- Offset. If the improper payment is still outstanding and amounts are not available to be withheld, then the employer is to apply a substitution or offset approach against subsequent valid claims, up to the amount of the improper payment.
- Treat Payment as Other Business Indebtedness. If the above correction efforts prove unsuccessful, then the employee remains indebted to the employer for the amount of the improper payment. In that event, and consistent with its business practices, the employer may treat the payment as it would treat any other business indebtedness

IX Flexible Spending Account Contacts

A. Plan Administrator

Humana Spending Account Administration
PO Box 14167
Lexington, KY 40512-1467

Customer Service:
(800) 604-6228
(800) 905-1851 (FAX)

B. Paper reimbursement requests

If employees do not use the Humana*Access* VISA card to pay for out of pocket expenses, they may mail or fax paper claims for reimbursement of expenses incurred to the above address or fax number, respectively. Reimbursement forms may also be found in our Web site at www.kehp.ky.gov.

C. Flexible Benefits Branch

If you or your employees have questions regarding eligibility for your Flexible Spending Account contact:

Personnel Cabinet
Department of Employee Insurance

Flexible Benefits Branch
501 High Street, 2nd Floor
Frankfort, KY 40601
(502) 564-0350 or (502) 564-0351
(502) 564-0364 (FAX)

Glossary of Terms

Change in Status – Any event that changes the following:

(a) legal marital status (marriage, death of spouse, divorce, legal separation or annulment);
(b) number of dependents of qualifying individuals (for Dependent Care Assistance only), (birth, adoption, placement for adoption, or death of a dependent child);
(c) employment status (commencement or termination of work; strike or lockout; commencement or return from an unpaid leave of absence; or any benefit eligibility condition that depends on employment status, whereby an employment status change would result in an individual either becoming, or ceasing to be, eligible under a plan for Employee, Spouse or Dependent);
(d) dependent status (employee's dependent child satisfies, or ceases to satisfy, coverage requirements due to attainment of age or any similar circumstance);
(e) residence or work site (change in Employee's, Spouse's or Dependent's place of residence or employment); and
(f) such other events as may be permitted by law or regulation.

COBRA – The Consolidated Omnibus Budget Reconciliation Acts of 1986, as amended, including parallel provisions as outlined in Title XXII of the Public Health Service Act. COBRA allows employees to continue their group health insurance coverage for a period of time.

Couple Coverage – Coverage for employee and their eligible covered spouse.

Coverage Level – Single, parent plus, couple or family coverage.

Creditable Coverage - Prior coverage by a covered person under any of the following:
(a) a group health plan, including church and governmental plans;
(b) health insurance coverage;
(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(d) Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act;
(e) the health plan for active and certain former military personnel, including CHAMPUS and TRICARE;
(f) the Indian Health Service or other tribal organization program;
(g) a state health benefits risk pool;
(h) the Federal Employees Health Benefits Program;
(i) a public health plan as defined in federal regulations**;**
(j) a health benefit plan under section 5(e) of the Peace Corps Act; and any other plan which provides comprehensive hospital, medical, and surgical services and meets federal requirements.

Creditable coverage does not include any of the following:

- accident only coverage, disability income insurance, or any combination thereof;
- supplemental coverage to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage for on-site medical clinics;
- benefits if offered separately:
  - limited scope dental and vision;
  - long-term care, nursing home care, home health care, community based care, or any combination thereof; and
  - other similar, limited benefits.
- benefits if offered as independent, non-coordinated benefits:
  - specified disease or illness coverage; and
  - hospital indemnity or other fixed indemnity insurance.
- benefits if offered as a separate policy:
  - Medicare Supplement insurance;
  - supplemental coverage to the health plan for active and certain former military personnel, including CHAMPUS and TRICARE; and
  - similar supplemental coverage provided to group health plan coverage.

Cross-Reference – A husband and wife who, as eligible employees of the KEHP, may elect to have both state paid contributions applied to their family coverage.

Dual Employment – Employees who work full-time for different agencies (i.e. school board and state agency) and who meet the eligibility requirements for both employers.

Effective Date – The date on which coverage for a covered person begins.

Eligible Employee – A person who meets the eligibility requirements of the KEHP and their employer.

Employee – A person who is employed by agencies of the KEHP and eligible to apply for coverage under a KEHP.

Family Coverage – Coverage for the employee, the employee's spouse under a legally valid existing marriage and one or more dependent children.

Kentucky Employees' Health Plan (KEHP) – The group, which is composed of eligible employees of state agencies, boards of education, health departments, quasi agencies, retirees of KCTCS, retirees of the Kentucky Retirement Systems, Teachers' Retirement System, the Legislators Retirement Plan and the Judicial Retirement Plan who are under age 65, and their eligible dependents.

Late Enrollee – An eligible employee who requests enrollment in a plan after the initial open enrollment period. An individual shall not be considered a late enrollee if:

- The person enrolls during their initial enrollment period;
- The person enrolls during any annual open enrollment period; or

- The person enrolls during a special enrollment period.

Member – Any employee, retiree, COBRA participant or dependents that are covered by one of the health plans offered by the KEHP.

Open Enrollment – a defined period of time, prior to the beginning of a Coverage Period during which an employee shall be entitled to elect benefit options for the subsequent coverage period.

Parent Plus – Coverage for the employee and eligible dependents, except the spouse.

Plan Year – Each successive twelve-month period starting on January 1 and ending on December 31.

Premium – The periodic charges due which the employee, or the employee's group, must pay to maintain coverage.

Premium Due Date – The date on which a premium is due to maintain coverage under the KEHP.

Qualified Beneficiary – Any individual who, on the day before a COBRA Qualifying Event, is covered under the Plan by virtue of being on that day a covered person, or any child who is born or placed for adoption with an employee during a period of COBRA continuation coverage.

Qualifying Event – A specific situation or occurrence that enables an eligible employee to enroll or terminate coverage outside the designated enrollment period as a result of that person becoming eligible for or losing eligibility for coverage under this Plan or another plan.

Retiree – A retiree of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Legislators Retirement Plan, Judicial Retirement Plan or any other state retirement system, who is under age 65.

Semi-monthly billing period - For purposes of health insurance the semi-monthly billing period is the first through the fifteenth of the month and the sixteenth through the last day of the month.

Single Coverage – Coverage for the employee/retiree only.

Special Enrollment Period – A period of time during which an eligible employee or dependent who loses other health insurance coverage or incurs a change in status may enroll in the plan without being considered a late enrollee.

SAMPLE
USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: *(Employee)*

FROM: Insurance Coordinator

DATE:

SUBJECT: **Notice to Active Employees Age 65 and Over**

This letter is to inform an active employee nearing the age of 65 or an employee 65 or older, of his/her health insurance options upon becoming eligible for Medicare. Any individual age 65 or older (and his/her spouse age 65 or older) who has current employment status is entitled to the same benefits under the employer's group health plan, under the same conditions as any such individual (or his/her spouse) under age 65.

The Medicare Secondary Payer rules specify when a group health plan must pay primary and when it may pay secondary if an individual is eligible for coverage under both a group health plan and Medicare. The rules also provide that employers may not offer individuals entitled to Medicare financial or other incentives to opt out of employer-provided group health coverage, and they prohibit certain actions that "take into account" an individual's Medicare entitlement.

Employer-sponsored group health insurance offered to current workers, regardless of Medicare status, is generally the primary payer for individuals covered through their own or a spouse's *current* employment.

MEDICARE

You will receive information regarding Medicare enrollment approximately three months prior to your 65th birthday. Medicare is divided into two main parts, which differ in terms of benefits, eligibility, and administration. Part A is the hospital insurance program. Part B is the supplementary medical insurance program, covering physicians' services and other health care expenses. In addition, individuals who are entitled to these Parts of Medicare may also be eligible for the Medicare Advantage program (Part C) or for certain prescription drug benefits (Part D).

If you are eligible for Medicare Part A, the coverage will be free and enrollment will be automatic. Medicare Part B is **not** free and enrollment is not automatic. You are encouraged to contact your local Social Security office to determine your eligibility for these programs.

Your individual retirement system is the best source for information about your eligibility for Medicare Supplement plans that may be available to you through a retirement benefit.

KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

Your Medicare eligibility or enrollment does not affect your eligibility to continue coverage with the KEHP as long as you continue to meet the eligibility requirements as an employee. However, your eligibility to participate in the Kentucky Retirement System(s) Medicare Supplement (KERS/CERS, Judicial or Legislative Retirement) plan will be affected. Please contact your retirement system for additional information about your eligibility for a Medicare Supplement plan.

Under the Medicare Secondary Payer ("MSP") statute, employer group health plans, like the KEHP, must pay primary to Medicare for employees who are eligible for the employer's group health plan ("GHP") coverage by reason of their "current employment status." *See* 42 U.S.C. § 1395y(b); 42 C.F.R. § 411.100(a)(1)(i). If an employee retires and then returns to work, and the retiree works enough hours to qualify for coverage (avg. 100 hours/month) under the employer's group health plan for active employees, federal regulations require the employer to treat the retiree as an active employee for purposes of the MSP rules:

> A reemployed retiree or annuitant who is covered by a GHP and who performs sufficient services to qualify for coverage on that basis (that is, other employees in the same category are provided health benefits) is considered covered "by reason of current employment status" even if: (1) The employer provides the same GHP coverage to retirees; or (2) The premiums for the plan are paid from a retirement or pension fund. See 42 C.F.R. § 411.172(d).

Thus, in general, as Medicare eligible full-time active employee, you may not maintain Kentucky Retirement System(s) Medicare Supplement (KERS/CERS, Judicial or Legislative Retirement) plan. Rather, you must elect: **1)** KEHP health plan (i.e. Optimum PPO, Capital Choice); **2)** the "waiver" HRA offered by the KEHP; **or 3)** no state coverage and only maintain Medicare coverage. If an active employee chooses to participate in any group health plan (KEHP health plan or "waiver" HRA) maintained by the employer, the employer's group health plan must pay primary to Medicare.

EMPLOYEE OPTIONS

A. Health Insurance: Since you will be eligible to participate in Medicare and the KEHP, you should compare the cost of each, the benefits of each and make your decisions based upon your needs.

You may choose Medicare Parts A & B as your only source of coverage and waive your state sponsored health insurance. There is a monthly premium for Medicare Part B.

You may choose not to enroll in Medicare Part B and continue in the KEHP. You may delay enrollment in Medicare Part B until a later date, however, you will need to contact

your local Social Security office regarding the Special Enrollment requirements, including dates.

Contact your local Social Security office or check the Centers for Medicare/Medicaid Services website to obtain all the information necessary to make your decisions.

Your individual retirement system is the best source for information about your eligibility for a Medicare Supplement plan.

B. Waiver HRA: New Employees age 65 or who will be 65 upon the effective date of their KEHP insurance coverage have a choice to be covered by their active employer through KEHP or through their benefit under Medicare.

C. Waiver No HRA. You will only maintain Medicare.

If you have questions, contact your Retirement System, Insurance Coordinator or the Enrollment Branch at 502-564-1205.

M E M O R A N D U M

TO: New Employees or Prospective Health Insurance Enrollees

FROM: (Name of State Agency, Board of Education, Local Health Department, KCTCS, etc.)

DATE:

NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for you, your spouse and/or any of your eligible dependents because of other health insurance coverage, you may be able to make a mid-year change in the Kentucky Employees Health Plan (KEHP) if you/they lose the other health coverage. If other health coverage is lost, you must request enrollment in the KEHP no later than 35 days of the loss.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or the placement for adoption, you may be able to enroll yourself, your spouse, and/or your dependents in the KEHP, provided that you request enrollment within 35 days of the date of the event. You will have 60 days from the date of birth to add newborns or newly adopted or placed children. However, if you choose to add other eligible dependents at that time, the change must be made no later than 35 days.

NOTICE ABOUT WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act requires the Commonwealth to notify you, as a participant in the KEHP, of your rights related to benefits provided through the program in connection with a mastectomy. You have rights to coverage provided in a manner determined in consultation with your attending physician for:

(1) all stages of reconstruction of the affected breast ;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the Plan's regular deductible, if any, and applicable co-payment or co-insurance amounts, depending upon the plan type and coverage option you have selected. For further details, please refer to your Summary Plan Description.

Keep this notice for your records.

Commonwealth of Kentucky
Department of Employee Insurance
2010 KEHP Checklist for New Employees

Name	Social Security Number
Agency Name	Agency #

Following is a list of your rights and responsibilities regarding the Kentucky Employees' Health Plan (KEHP). Read this form carefully and make sure you understand each item. You may direct your questions to your Insurance Coordinator at _____ or you may contact the Department of Employee Insurance at 888-581-8834 or 502-564-1205.

As a new employee, I understand that:

_____I have 30 calendar days from my date of employment to make a health insurance election under the Kentucky Employees Health Plan (KEHP), which includes enrolling in a health insurance plan, Flexible Spending Account and/or waiving coverage. The 30 days are counted beginning with the day after my hire date. If I am an employee of an agency that has a different probationary period, I must sign and date my application no later than 30 days prior to my coverage effective date.

_____ I have received and read the "Notice to Employees 65 and Over"

_____ I understand that If I am 65 or over that I have same opportunity to enroll in KEHP as any other active employee.

_____I understand that if I am a return to work retiree over 65 and/or Medicare eligible that I may not be eligible to continue under a Medicare supplement plan offered by a Kentucky retirement system. I must call my retirement system and verify whether I will be eligible for a Medicare supplement or whether I should consider enrolling in a KEHP plan.

_____ I understand that if I am Medicare eligible that my KEHP Health Plan or stand-alone HRA will pay for Medicare-covered expenses, up to the limit of my coverage under the Kentucky program, before applying to Medicare for payment.

_____I must submit all applications for health insurance (including a waiver of coverage) and Health Reimbursement Account/Flexible Spending Accounts to my agency's Insurance Coordinator **OR** I must make my elections under the KEHP via Web Enrollment.

_____ I will be subject to a one time, 12 month waiting period for pre-existing conditions unless I have had prior creditable coverage for at least 12 months and have had less than a 63 consecutive day break in coverage between the termination of that coverage and the effective date of my coverage with the KEHP. Any prior period of coverage that is less than 12 months will be applied against the pre-existing condition waiting period.

_____ I must indicate my level of coverage on my application

- SINGLE – Employee Only
- PARENT PLUS – Employee and dependent child(ren)
- COUPLE – Employee and spouse
- FAMILY – Employee, spouse, and dependent child(ren)

_____Once I make my insurance elections, I can not change those elections for the Plan Year unless I experience a valid Qualifying Event or during the Open Enrollment Period.

_____If I meet all requirements and elect to start a cross-reference payment option with my spouse, who is an existing employee of the KEHP and one of us terminates employment, the remaining employee will be set up with a Parent Plus plan.

_____If I fail to enroll within the specified deadline, I will be set up as a waiver with no Health Reimbursement Account. I will only be able to enroll in the KEHP a) if a Qualifying Event takes place that would allow me to enroll or b) during the Open Enrollment Period.

_____Every year there is a defined Open Enrollment Period for health insurance that provides me the opportunity to make ANY type of change in my health insurance coverage and Health Reimbursement/Flexible Spending Account Program, if applicable.

NOTE: CHILDREN COVERED BY COURT ORDER OR ADMINISTRATIVE ORDER MAY NOT BE DROPPED FROM MY INSURANCE, EVEN DURING OPEN ENROLLMENT, UNLESS THERE IS A SUBSEQUENT COURT OR ADMINISTRATIVE ORDER.

_____Outside of the annual Open Enrollment Period, I will only be allowed to make changes to my current plan and, in appropriate circumstances, change plans **within 35 calendar days of a Qualifying Event or up to 60 calendar days for newborns and adoptions (see the Health Insurance Handbook for more information on adding newborns/adoptions and when they will be effective)**. A list of Qualifying Events is available from your Insurance Coordinator or the KEHP's web site at www.kehp.ky.gov.

_____I have been directed to the Summary Plan Description on the KEHP's web site (www.kehp.ky.gov) where I can find all relevant information pertaining to my insurance coverage.

_____I have been directed to the Kentucky Employees Health Plan Handbook on the KEHP's web site where I can find all relevant information pertaining to my options for health insurance coverage.

_____It is my responsibility to sign and date the appropriate form requesting corresponding changes to my plan and give to my agency's Insurance Coordinator no later than 35 calendar days of any event that may affect my coverage.

_____The State offers a Premium Conversion program that allows me to pay my portion of the health insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in health insurance, unless I sign a post-tax form **OR** my dependent(s) does not meet the pre-tax qualifications.

_____My coverage will begin no earlier than on the first day of the second month following my employment hire date.

_____If I experience a COBRA Qualifying Event, such as, but not limited to, termination of employment, I have the right to continue my health insurance at my own expense under COBRA.

_____If I decide that I do not want the state-sponsored health insurance at this time, I can waive (decline) coverage by completing the appropriate paperwork. If I waive coverage because I am covered under my spouse's plan, I will be allowed to enroll in a plan through the KEHP if one of the following occurs:
1. my spouse's employer group health insurance terminates;
2. loss of eligibility;
3. if COBRA coverage is involved, the COBRA coverage expires;
4. my spouse's employer ceases contributing to the plan; or
5. loss of a group health insurance policy.

Check with your spouse's health plan before waiving coverage. Some companies will not cover you if you are eligible for health benefits through your own employer.

_____I may have the opportunity to enroll in the Flexible Spending Account (FSA) program, if applicable, no later than 30 calendar days from my date of employment. I have obtained the appropriate FSA information and application and have been given a chance to ask questions pertaining to the coverage by my Insurance Coordinator.

_____I may contribute my own money into either the Healthcare FSA or Dependent Care FSA. Once I have directed money into the Healthcare FSA, changes are permitted for a HIPAA Special Enrollment Right or a Change in Status (Qualifying Event) if the change is requested no later than 35 calendar days of the date of the event. Changes are allowed to the Dependent Care FSA with an approved Change in Status. Refer to the Qualifying Event Chart.

NOTE: NO QUALIFYING EVENT ALLOWS MEMBERS TO STOP HEALTH INSURANCE IN ORDER TO ENROLL IN A HEALTH REIMBURSEMENT ACCOUNT.

Have you worked for any other agency participating in the Kentucky Employees Health Plan within the last 11 days?
Yes ___ No ___
If yes, please give name of agency and date terminated or transferred.

_____ _____/_____/_____
Agency **Last day worked**

Are you retired from a state-sponsored retirement system?
Yes ___ No ___
If yes, please specify which system:
_____Judicial Retirement Plan
_____Legislators Retirement Plan
_____KCTCS
_____Kentucky Retirement Systems
_____Kentucky Teachers' Retirement System

I acknowledge that I have received copies of the following:
_____Flexible Spending Account Information, if applicable
_____Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act
_____Other _____

I certify that I have had my health insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

_____ _____
Employee Signature **Date**

_____ _____
Agency Representative **Date**

SAMPLE

USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: *(Employee on LWOP)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved LWOP

As an employee on Leave Without Pay (LWOP), you are eligible to continue your Health Insurance, Health Reimbursement Account or Healthcare Flexible Spending Account at your own expense through COBRA. You must contact *(Insurance Coordinator)* to make arrangements to continue your benefits.

Health Insurance

To continue your group health insurance coverage you must pay the premiums through COBRA.

A. If you are on LWOP and you have pay during the semi-monthly period the leave starts, please check with the Insurance Coordinator for your agency for information as to when your health insurance, stand-alone HRA or FSA coverage will end. If your pay for the semi-monthly period is not sufficient to cover the employee's portion of the premium, you will need to submit a check for the amount due.

   Any portion of a premium due by you must be submitted to the Insurance Coordinator by the 20th of the month. The check must be payable to the Kentucky State Treasurer and have your Social Security Number listed on the check. The Insurance Coordinator will forward the payment to DEI.

   NOTE: If you fail to submit appropriate premium payments due within the specified deadline, the Plan will cancel the ENTIRE POLICY.

B. If you will be on LWOP for and loose eligibility under the Plan, you may continue your coverage through COBRA. You will need to fill out the COBRA election form and submit it, with your payment, to Ceridian. Follow the instructions provided with your COBRA materials.

Health Care Flexible Spending Account

If you are eligible and you decide to continue your participation in the Healthcare FSA, you must submit a check to your Insurance Coordinator, in the amount of $_____ made payable to the Kentucky State Treasurer.

When you return to work after being on LWOP , please check with your Insurance Coordinator for information concerning when you coverage will resume.

When you return from LWOP your length of absence may affect your health insurance. If you do not elect to continue health insurance while on LWOP, and have more than a 63 day break in coverage, you will be subject to pre-existing conditions when your coverage resumes.

When you return to work after being on LWOP you will not be eligible to make any changes to the health insurance coverage in which you were enrolled prior to the LWOP unless one of the following has occurred:

- You experience a Qualifying Event and you apply for an appropriate change within 35 days of returning to work, except when adding a child ONLY due to birth, adoption, or placement for adoption, which would require you to apply within 60 days.

- You return in a new Plan Year or after missing the Open Enrollment period and you apply for a coverage change no later than 35 days after your return.

- The coverage in which you were enrolled prior to the beginning of the LWOP is not available upon your return. You will have no more than 35days after your return to apply for an appropriate change.

The Insurance Coordinator must provide the necessary applications upon return.

Should you have any questions, you may contact me at _____.

SAMPLE

USE YOUR AGENCY LETTERHEAD

MEMORANDUM

TO: *(Employee on Family Leave)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved Family Medical Leave (FMLA)

This letter is to inform you of your health insurance responsibilities as an employee on Family Medical Leave (FMLA). As an employee on FMLA, the state will continue to make the employer contributions for your health insurance or health reimbursement account, if applicable. It is your responsibility to make timely payments of any employee contribution amounts that had previously been deducted for health insurance or for Flexible Spending Accounts.

Health Insurance

While on FMLA, two conditions must be met in order to qualify for the employer contribution for health insurance. The first is you must maintain the level of coverage that was in effect before going on leave. Secondly, you must pay the employee contribution, if applicable. To continue your health insurance you must submit a check made payable to the Kentucky State Treasurer, in the amount of $_____ (employee contribution). You check must be received by me before _____(insert date).

Flexible Spending Account *(if applicable)*

If you are enrolled in the Kentucky Employees' Health Plan's Flexible Spending Account Program, you may submit a check in the amount of $_____ made payable to the Kentucky State Treasurer. Your check must be received by me before _____(insert date) If you choose to not continue participating in the FSA program, your annual election amount will be reduced by the per semi-monthly contribution amount. If you wish to resume your employee contribution when you return from FMLA, you must complete an FSA Qualifying Event Change Form.

The payments for health insurance and Flexible Spending Accounts should be submitted to the following address by the _____(insert date) of each month. Please include your Social Security Number on each check.

_____

_____

If you exhaust your FMLA time before you are able to return to work you will be placed on Leave Without Pay (LWOP) and may be eligible for COBRA. If eligible, you will be sent a COBRA notification letter, which allows you to continue your health insurance and Healthcare FSA totally at your own expense. Should you opt not to continue under COBRA, you will be restored to your previous level of coverage immediately upon your return to work.

If you have any questions, please feel free to contact me at _____.

Personnel Cabinet
Department of Employee Insurance

2010 Health Insurance Total Monthly Premiums

	Single	Couple	Parent Plus	Family
Commonwealth Standard PPO	$486.40	$1,127.80	$749.84	$1,253.56
Commonwealth Capitol Choice	$594.14	$1,347.50	$896.06	$1,490.60
Commonwealth Optimum PPO	$616.28	$1,363.40	$889.54	$1,515.36
Commonwealth Maximum Choice	$575.42	$1,177.68	$851.46	$1,341.52

Employee Contributions

Monthly employee contribution* – Non-Smoker

	Single	Couple	Parent Plus	Family	Family Cross-Reference*
Commonwealth Standard PPO	$0	$282.18	$8.28	$288.44	$0
Commonwealth Capitol Choice	$5.00	$444.12	$144.02	$525.84	$12.88*
Commonwealth Optimum PPO	$27.50	$469.52	$176.52	$561.16	$28.34*
Commonwealth Maximum Choice	$0	$334.66	$108.86	$398.32	$9.66*

Monthly employee contribution* – Smoker

	Single	Couple	Parent Plus	Family	Family Cross-Reference*
Commonwealth Standard PPO	$24.00	$330.18	$56.28	$336.44	$24.00*
Commonwealth Capitol Choice	$29.00	$492.12	$192.02	$573.84	$36.88*
Commonwealth Optimum PPO	$51.50	$517.52	$224.52	$609.16	$52.34*
Commonwealth Maximum Choice	$24.00	$382.66	$156.86	$446.32	$33.66*

* Contribution is per employee

2010 COBRA Rates

	Single	Couple	Parent Plus	Family
Commonwealth Standard PPO	$496.13	$1,150.36	$764.84	$1,278.63
Commonwealth Optimum PPO	$628.61	$1,390.67	$907.33	$1,545.67
Commonwealth Maximum PPO	$586.93	$1,201.23	$868.49	$1,368.35
Commonwealth Capitol Choice	$606.02	$1,374.45	$913.98	$1,520.41
HRA Waiver	$169.58			

2010 COBRA Calendar

QUALIFYING EVENT DATE	18 MONTHS	36 MONTHS
12/09	06/30/2011	12/31/2012
01/10	07/31/2011	01/31/2013
02/10	08/31/2011	02/28/2013
03/10	09/30/2011	03/31/2013
04/10	10/31/2011	04/30/2013
05/10	11/30/2011	05/31/2013
06/10	12/31/2011	06/30/2013
07/10	01/31/2012	07/31/2013
08/10	02/28/2012	08/31/2013
09/10	03/31/2012	09/30/2013
10/10	04/30/2012	10/31/2013
11/10	05/31/2012	11/30/2013
12/10	06/30/2012	12/31/2013

County and Group Number Table

FIPS	CO. NO.	COUNTY NAME	AREA	GROUP NO.
001	001	ADAIR	LEX	P6070
003	002	ALLEN	LOU	P5941
005	003	ANDERSON	LEX	P6070
007	004	BALLARD	LOU	P5941
009	005	BARREN	LOU	P5941
011	006	BATH	LEX	P6070
013	007	BELL	LEX	P6070
015	008	BOONE	N.KY	P6070
017	009	BOURBON	LEX	P6070
019	010	BOYD	LEX	P6070
021	011	BOYLE	LEX	P6070
023	012	BRACKEN	LEX	P6070
025	013	BREATHITT	LEX	P6070
027	014	BRECKINRIDGE	LOU	P5941
029	015	BULLITT	LOU	P5941
031	016	BUTLER	LOU	P5941
033	017	CALDWELL	LOU	P5941
035	018	CALLOWAY	LOU	P5941
037	019	CAMPBELL	N.KY	P6070
039	020	CARLISLE	LOU	P5941
041	021	CARROLL	LOU	P5941
043	022	CARTER	LEX	P6070
045	023	CASEY	LEX	P6070
047	024	CHRISTIAN	LOU	P5941
049	025	CLARK	LEX	P6070
051	026	CLAY	LEX	P6070
053	027	CLINTON	LEX	P6070
055	028	CRITTENDEN	LOU	P5941
057	029	CUMBERLAND	LEX	P6070
059	030	DAVIESS	LOU	P5941
061	031	EDMONSON	LOU	P5941
063	032	ELLIOTT	LEX	P6070
065	033	ESTILL	LEX	P6070
067	034	FAYETTE	LEX	P6070
069	035	FLEMING	LEX	P6070
071	036	FLOYD	LEX	P6070
073	037	FRANKLIN	LEX	P6070
075	038	FULTON	LOU	P5941
077	039	GALLATIN	N.KY	P6070
079	040	GARRARD	LEX	P6070
081	041	GRANT	N.KY	P6070
083	042	GRAVES	LOU	P5941
085	043	GRAYSON	LOU	P5941
121	061	KNOX	LEX	P6070
123	062	LARUE	LOU	P5941
125	063	LAUREL	LEX	P6070
127	064	LAWRENCE	LEX	P6070
129	065	LEE	LEX	P6070
131	066	LESLIE	LEX	P6070
133	067	LETCHER	LEX	P6070
135	068	LEWIS	LEX	P6070
137	069	LINCOLN	LEX	P6070
139	070	LIVINGSTON	LOU	P5941
141	071	LOGAN	LOU	P5941
143	072	LYON	LOU	P5941
151	076	MADISON	LEX	P6070
153	077	MAGOFFIN	LEX	P6070
155	078	MARION	LOU	P5941
157	079	MARSHALL	LOU	P5941
159	080	MARTIN	LEX	P6070
161	081	MASON	LEX	P6070
145	073	MCCRACKEN	LOU	P5941
147	074	MCCREARY	LEX	P6070
149	075	MCLEAN	LOU	P5941
163	082	MEADE	LOU	P5941
165	083	MEIFEE	LEX	P6070
167	084	MERCER	LEX	P6070
169	085	METCALFE	LOU	P5941
171	086	MONROE	LOU	P5941
173	087	MONTGOMERY	LEX	P6070
175	088	MORGAN	LEX	P6070
177	089	MUHLENBURG	LOU	P5941
179	090	NELSON	LOU	P5941
181	091	NICHOLAS	LEX	P6070
183	092	OHIO	LOU	P5941
185	093	OLDHAM	LOU	P5941
187	094	OWEN	LEX	P6070
189	095	OWSLEY	LEX	P6070
191	096	PENDLETON	N.KY	P6070
193	097	PERRY	LEX	P6070
195	098	PIKE	LEX	P6070
197	099	POWELL	LEX	P6070
199	100	PULASKI	LEX	P6070
201	101	ROBERTSON	LEX	P6070
203	102	ROCKCASTLE	LEX	P6070
205	103	ROWAN	LEX	P6070

FIPS	CO. NO.	COUNTY NAME	AREA	GROUP NO.
087	044	GREEN	LOU	P5941
089	045	GREENUP	LEX	P6070
091	046	HANDCOCK	LOU	P5941
093	047	HARDIN	LOU	P5941
095	048	HARLAN	LEX	P6070
097	049	HARRISON	LEX	P6070
099	050	HART	LOU	P5941
101	051	HENDERSON	LOU	P5941
103	052	HENRY	LOU	P5941
105	053	HICKMAN	LOU	P5941
107	054	HOPKINS	LOU	P5941
109	055	JACKSON	LEX	P6070
111	056	JEFFERSON	LOU	P5941
113	057	JESSAMINE	LEX	P6070
115	058	JOHNSON	LEX	P6070
117	059	KENTON	N.KY	P6070
119	060	KNOTT	LEX	P6070
207	104	RUSSELL	LEX	P6070
209	105	SCOTT	LEX	P6070
211	106	SHELBY	LOU	P5941
213	107	SIMPSON	LOU	P5941
215	108	SPENCER	LOU	P5941
217	109	TAYLOR	LOU	P5941
219	110	TODD	LOU	P5941
221	111	TRIGG	LOU	P5941
223	112	TRIMBLE	LOU	P5941
225	113	UNION	LOU	P5941
227	114	WARREN	LOU	P5941
229	115	WASHINGTON	LOU	P5941
231	116	WAYNE	LEX	P6070
233	117	WEBSTER	LOU	P5941
235	118	WHITLEY	LEX	P6070
237	119	WOLFE	LEX	P6070
239	120	WOODFORD	LEX	P6070

2010 COBRA Carrier Codes

	Group# P5941 Louisville Area	Group# P6070 Lexington Area	Group# P6077 No. Ky/Cin Area
Commonwealth Standard PPO	CHLJ	CHMM	CHNP
Commonwealth Maximum Choice	DAI1	DAJE	DAJR
Commonwealth Optimum PPO	CHLW	CHMZ	CHN2
Commonwealth Capitol Choice	ETJM	ETJZ	ETKC
HRA Waiver	DJ4A	DJ3X	DJ4N

QE of Death Chart

Qualifying Events dropping self/dependents : Termination of Coverage for Health Insurance

Plan changes must be signed within 35 days of the date of death.
Additional information is under Qualifying Events in the Administration Manual

Plan Level	Death of:	Date of Death	Coverage Ends	IC Submits	Premiums
Single	Member	1st – 15th	Date of Death	Update form	No premium due
	Member	16th – End of Month	Date of Death	Update form	Full month due
Couple Plan	Member	1st – 15th	End of Current Month	Enter Dependent in Ceridian. Enter end of month as termination date.	Full month due
	Member	16th – End of Month	End of Current Month	Same as above	Full month due
	Dependent	1st – 15th	End of Current Month	Dependent Drop form/ Application - member in Single Plan. Effective first of next month	Full month due
	Dependent	16th – End of Month	End of Current Month	Same as Above	Full month due
Parent Plus	Member	1st – 15th	End of Current Month	Enter Dependent in Ceridian. Termination date end of month	Full month due
	Member	16th – End of Month	End of Current Month	Same as Above	Full month due
	Dependent	1st – 15th	End of Current Month	Dependent Drop Form. If was only 1 (one) dependent, Enrollment form to change to single plan. Eff. 1st of next month	Full month due
	Dependent	16th – End of Month	End of Current Month	Same as above	Full month due
Family Plan	Member	1st – 15th	End of Current Month	Enter Dependent in Ceridian. Enter end of month as termination date.	Full month due

Plan Level	Death of:	Date of Death	Coverage Ends	IC Submits	Premiums
Family Plan	Member	16th – End of Month	End of Current Month	Same as above	Full month due
	Dependent	1st – 15th	End of Current Month	Dependent Drop form. Enrollment form for Couple or Parent Plus effective first of next month.	Full month due
	Dependent	16th – End of Month	End of Current Month	Same as above.	Full month due
Family X-Ref	Member/ Spouse	1st – 15th	End of Current Month	Cross Ref Broken Update Form for Death; Enrollment Form for Parent Plus effective 1st of next month.	Full month due
	Member/ Spouse	16th – End of Month	End of Current Month	Cross Ref Broken Update Form for Death; Enrollment Form for Parent Plus effective 1st of next month.	Full month due
Family X-Ref	Dependent	1st – 15th	End of Current Month	**Multiple children** no change. **Death of only child**: Drop Form and Enrollment form for Couple or (2) Single Coverage effective 1st of next month.	Full month due
	Dependent	16th – End of Month	End of Current Month	Same as above	Full month due

Qualifying Event of Death –
Flexible Spending Accounts and stand-alone Health Reimbursement Accounts

	Death of:	Date of Death	Coverage Ends	Contributions
Flexible Spending Account & Health Reimbursement Account	Member	1st – 15th	Date of Death	½ of the monthly contribution
	Member	16th – End of Month	Date of Death	Full Monthly contribution

There are many variables to consider with a Flexible Spending Account and/or a Health Reimbursement Account. As to what steps to take after the death of a member or a dependent, are contingent upon many different factors. Please refer to the Administration Manual for specifics.

ADDITIONAL NOTICES

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If *you* have had or are going to have a mastectomy, *you* may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the covered mastectomy was performed;
- *Surgery* and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending *provider* is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending *provider* does not include a plan, *hospital*, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MICHELLE'S LAW

This *Plan* is compliant with Michelle's Law, effective January 1, 2010. Under Michelle's Law, this *Plan* must continue to provide coverage to a "dependent child" if the child takes a leave of absence from a postsecondary educational institution, or has a change in enrollment status, that:

- Begins when the student is suffering from a serious injury or illness;
- Is *medically necessary* (as confirmed in a written communication from the student's treating physician); and
- Causes the child to lose student status for purposes of coverage under the *Plan*.

A "*dependent* child" for purposes of Michelle's Law is a child who (1) is a *dependent* child of a participant or beneficiary under the terms of the *Plan*, and (2) was enrolled in the *Plan* on the basis of being a student at a postsecondary educational institution immediately before the medical leave of absence began.

This *Plan* will continue the child's coverage for up to one year after the leave of absence begins or, if earlier, until coverage would have otherwise terminated under the terms of the *Plan*.

MENTAL HEALTH PARITY ACT (MHPA) AND MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This *Plan* operates in compliance with Mental Health Parity Act and the Additional Equity Act of 2008 as forth in the Public Health Service Act (PHSA).

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

This *Plan* is compliant with Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233 (2008), § 201(2)(B), to be codified at 42 U.S.C. § 2000ff. Section 701(b) of the Civil Rights Act of 1964 is codified at 42 U.S.C. § 2000e(b).